THE CANADIAN NURSE

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MONTREAL

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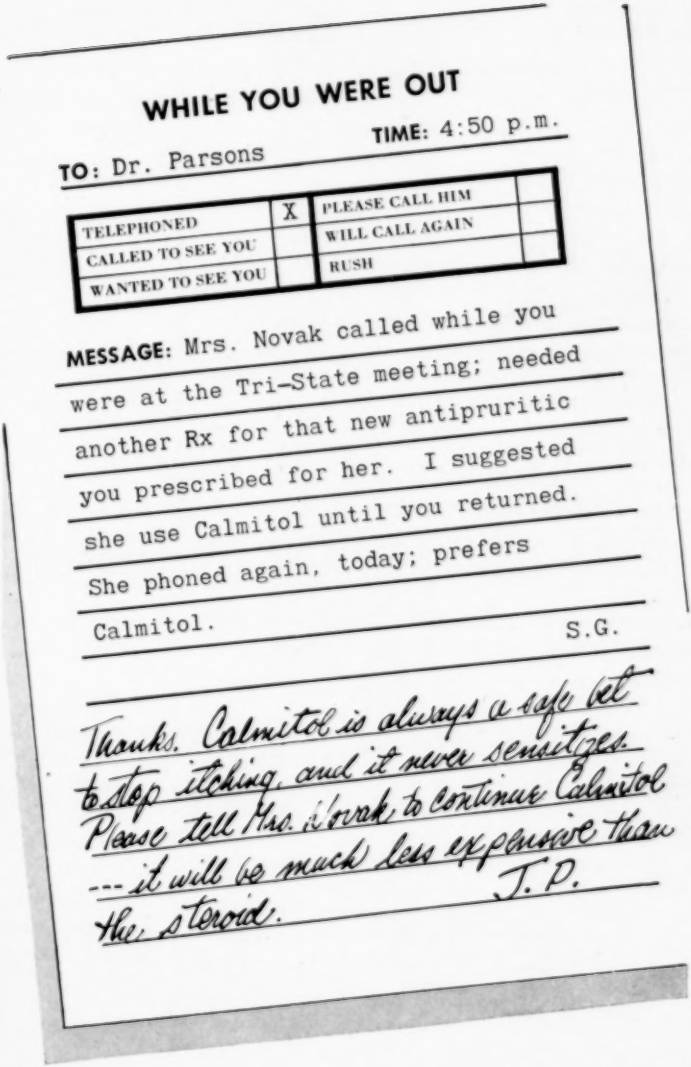

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THE CANADIAN NURSE

L'Infirmière canadienne

VOLUME 54 **NUMBER 1**

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of The Canadian Nurse *nor of the Canadian Nurses' Association.*

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Between Ourselves

DURING THE PAST two decades, starting each year with an inspirational message from the president of the Canadian Nurses' Association has become a tradition. We are most happy to welcome our president Trenna Grace Hunter as the guest editor for this first issue in 1958.

Last autumn when our Royal Patron, Her Majesty, Queen Elizabeth II and Prince Philip paid their official visit to Canada, Miss Hunter had the exciting pleasure of representing all of us at the State Reception. Turn to page 15 to read her account of this memorable experience.

* * *

You will have a new and probably different understanding of the prescription of "T.L.C." after you have read the article by Dr. Charles V. Willie. It may require considerable mental readjustment before the average nurse can see herself in the "receiving" rather than the "giving" role. Dr. Willie delivered this address at the Annual Conference arranged for the Department of Nursing Education of the School of Nursing, Syracuse (N.Y.) University and the Department of Public Health Nursing of the State University of New York College of Medicine.

* * *

Did your local newspaper carry much of a story of the premier Conference on Nursing? Possibly if you read a Toronto newspaper you would answer "yes" because their representative was present throughout the two days. Other papers relied upon the Canadian Press releases to a great extent. Miss Suzanne Giroux and your editor participated on behalf of the *Journal*. You will find our accounts in this issue and also two of the formal addresses that were given.

* * *

The long-promised series of articles on "simplified parliamentary procedure" commences in this number. Part I indicates the basic principles, the reasons why it is wise to observe some definite pattern in the conduct of meetings. Before the first brief article is even published it has been suggested to us that we should have reprints made of each part so that at the conclusion we shall be able to provide a low-priced compilation that you may secure for easy reference should it be desired. In the interests of oncoming generations of nurses, particularly, it seems to us an excellent idea.

* * *

New Year's Day is the time-honored occasion for making resolutions. Somewhat cynically, January 2 is usually suggested as the day when we start breaking our carefully prepared list of resolutions. We considered for quite a while sharing some of the resolutions that concern the Journal with you. Then, when we tried to write them down, we realized that a couple of them we could not keep without your help, any way. Perhaps instead of proposing some resolutions, we should express our sincere thanks for the cooperation so many of you give us and remind some of the rest of ways they may help us.

First of all, then, thank you to all of the subscribers who send in their changes of address so promptly when they move. Some months we have had between 750 and 1000 changes come in. That is wonderful! Mrs. Ruth Baumel is the clerk who makes the corrections, usually the very day they are received. Of course, if you don't give us four weeks' notice an issue may go to the old address because the envelope is already down at the printers.

How can we cut down on the number of undeliverable copies? As you know, the post office does not send on second class mail when people move. So each month we may have one, two or three hundred copies come back marked "Moved — no address." These people get annoyed when their copies don't arrive. How can we reach them?

We had several more paragraphs of thank you's ready but are quickly running out of space. So we shall condense them into a combined word of appreciation to those who write for us, to those who remember to ask for copies of good addresses they hear and send them to us, to those whose "News Notes" items arrive regularly. Keep up the good work of sharing this way.

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Edited by DEAN F. N. HUGHES

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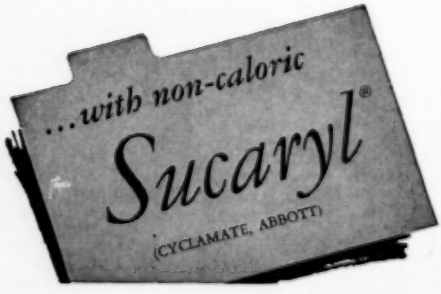

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THE CANADIAN NURSE

L'Infirmière canadienne

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 54 NUMBER 1

MONTREAL, JANUARY, 1958

Just a Mere Fifty Years

THE YEAR 1958 brings British Columbia to its centennial and every town and village is making great plans to celebrate the 100th anniversary of this province.

Another birthday of great importance is, of course, the 50th anniversary of our Canadian Nurses' Association which we are looking forward to celebrating in a fitting manner next June in Ottawa, the city of our birth.

With all the planning for birthday celebrations in which we find ourselves involved, we inevitably get drawn in to thinking and reading something about the history behind these celebrations.

Having so recently returned from the I.C.N. meeting in Rome, where history is measured not in hundreds but in thousands of years, one is suddenly aware of how very young we are in this country, and in this association, in terms of living. It is hard to project one's thinking back to 50 years ago, 100 years ago and almost impossible to visualize 2,000 years ago. And yet, where better than in Rome can one get the feel of history where, at every turn, we come upon the visible remains of a civilization 2,700 years old and reflect that here Christian nursing was born.

The famous Aurelian wall, built about 280 A.D., pushing its way across the city with the modern flow of traffic through its old gates, the ruins of Ostia, the remarkable restorations and the practice of leaving historic

(Tony Archer, Vancouver)

TRENNA G. HUNTER

ruins where they find them and building the modern city in and around them, fascinated those of us who are used to a bulldozer method of construction — away with the old, in with the new.

We longed for the time to read and refresh our knowledge of the "glory that was Greece and the grandeur that was Rome" but the inflexible program of meetings and discussions, the interesting visits to schools of nursing, to clinics and health centres kept us very much in the present — no time to linger over ruins! One could only recall dimly that Phoebe, Dorcas, Fabiola were names in nursing we should be able to remember in this setting.

Returning to the shores of the Pacific, we were just in time to hear a great deal about the plans for the 100th birthday. Stage coaches will roll again over the old route to the gold fields, history will be reenacted and old timers will revel in reminiscences of the good old days.

What about nursing in this province 100 years ago? In "Three Centuries of Nursing" we are told that one of the earliest hospitals had its beginning in 1858 when Rev. Edward Cridge rented a cottage in Victoria and started a temporary hospital for male patients. In 1864, the Royal Female Infirmary was established, the two being united in 1869 as the Victoria Royal — now the Royal Jubilee Hospital in Victoria.

Two orders, the Sisters of St. Ann and the Sisters of Providence, were important factors in the development of nursing in British Columbia — the Sisters of Providence setting up St. Mary's hospital in New Westminster in 1886. Much earlier, 1863, the Royal Columbian was established at New Westminster.

There are many tales of individual women who nursed in the gold fields, in the Hudson Bay posts and in the Indian villages. The story of the growth of nursing is just as romantic, just as spectacular as any development in this country. All across Canada from the remote mining centres of B.C. to the fishing villages of Newfoundland, one can trace the growth of history as nursing parallels and reflects the changing social conditions and general economy of Canada.

In celebrating the birthday of our own association we look back to find that, in order that Canada might be represented at the I.C.N. meeting in London in 1909, we must have a national organization. Miss Mary Agnes Snively undertook to call a meeting of the Executive Committee of the Society of Lady Superintendents to see what could be done. A questionnaire went out to all parts of the country (the first survey of nursing schools in Canada!) with the result that on October 8, 1908, in the Lady Stanley Institute in Ottawa, officers and members of the Society of Lady Superintendents and accredited delegates from 16 nursing organizations moved, seconded and duly carried

> that an association be formed forthwith and called the Provisional Organization of the Canadian National Association of Trained Nurses.

The way was paved for membership in the I.C.N. and 25 Canadian nurses attended the London meeting in 1909. Almost 50 years later the Canadian Nurses' Association was allotted 255 spaces at the XIth quadrennial meeting of the I.C.N. in Rome — the fourth largest delegation from the 57 countries attending.

History-making events have followed one upon the other over the 50 years of the Association's growth. Through all the years of growing, of struggling to become a "profession," of trying to move from "training" to "education" for nurses, of initiating surveys and studies, of experimenting with curricula and patterns of nursing schools, we have inclined to be a little defensive of our profession and have not sought the help of too many "outsiders" in helping us solve our problems.

Faced with another great social change in Canada, the probable advent of a hospital insurance plan, we knew that now, if ever, we must seek help and look critically at nursing through the eyes of those who would have a good deal to say about what would happen in the next few years to the profession. So on November 4 and 5, 1957, in Ottawa, the first Conference on Nursing was held. You can read a complete report of that conference in this number. Again, you will realize, history has been made.

In looking back over the list of distinguished women who have held the office of president of the CNA, I am filled with admiration and awe for the contribution each has made. Many of them are known to me personally, as eleven of the nineteen presidents the CNA has had are still active women. We are indeed young in the light of history, just a mere 50 years. We have paused to take a good look at ourselves through the eyes of the many friends who joined us in that November conference. Now we are ready "to look to the future and into it open a better way" as we embark on our next 50 years.

TRENNA G. HUNTER
President
Canadian Nurses' Association

Our President Meets the Queen

"TO HAVE THE HONOR to meet Her Majesty, Queen Elizabeth and His Royal Highness, The Prince Philip, Duke of Edinburgh" read the gold-crested invitation from the Prime Minister, and Mrs. Diefenbaker. It was indeed an honor, not only to the President of the CNA but to all members of the nursing profession that such an invitation was received.

The flurry of preparation began. "Not a thing to wear" is the age-old cry of every woman faced with looking her best for an occasion and certainly this was an occasion. With hurried expeditions at lunch hours and on days off, a costume was assembled, long white gloves unearthed, curtsies were practised, and we were "off to see the Queen."

Ottawa looked its very loveliest. The scarlet of flags and banners was not only matched but was excelled by the glory of the autumn colors on every tree and shrub. The flood-lit Parliament Buildings, the sparkle of thousands of lights and the general air of happiness and excitement made the city a fairyland.

The reception was held at 5:30 p.m. in the ballroom of the Chateau Laurier. We were there at 4:30 and lined up eight abreast down the long corridor leading to the ballroom.

Right on time, there was a flurry in the anteroom leading to the ballroom where the Cabinet Ministers and their wives stood waiting to receive the Royal couple. The R.C.M.P. band struck up the National Anthem, then the signal was given to enter in single file, gentlemen first. "Don't shake her hand too hard, her arm is very tired" we were warned by an aide.

The receiving line, consisting of the Prime Minister, Her Majesty, Prince Philip and Mrs. Diefenbaker stood in front of great standards filled with chrysanthemums in glowing orange, yellow and bronze.

The Queen was beautiful in a brocaded gold lamé dress with small matching hat and her favorite two-strand pearl necklace. The Prince wore a navy blue business suit. Both seemed so relaxed and happy that one felt they were really pleased to see a representative group of Canadian people.

We were not allowed to linger to savor the moment or to gaze at the lovely picture the Queen made. After murmuring "Mr. Prime Minister, Your Majesty, Your Royal Highness" and giving the semblance of a curtsey, we were urged forward to the ballroom where long tables were laden with refreshments. Members of the government and their wives were there, representatives of the armed forces, of business, of the church and of national organizations as well as deputy ministers and their wives and the Governor General's Foot Guards and their wives.

It was indeed a distinguished gathering and we were able to chat with many groups in the two hours. The receiving line lasted a full 90 minutes in which time 1323 hands were shaken, while the Prince spoke individually to several of the guests.

Then the party moved slowly through the long ballrooms, the Queen looking a little weary but still smiling. The guests applauded as they reached the door and disappeared — another performance well done!

We too prepared to leave feeling that the CNA, which had so recently received permission to have a Royal Patron were indeed fortunate to have such a gracious and charming one as Her Majesty, the Queen.

TRENNA G. HUNTER

Love for the Helping Professions

CHARLES V. WILLIE, PH. D.

LOVE IS A FEELING sometimes called an emotion. Much of our difficulty in dealing with love is due to our inability to comprehend it. The feeling, love, is varyingly thought of as a person, place, or thing — even a many-splendored thing. But love is not so complex as this. It is simply a feeling, albeit a most important feeling. It follows, then, that our faulty comprehension of love is associated with incomplete knowledge of it. Thus, we deal with this feeling in a most inadequate way. Social scientists have largely left the responsibility of describing, analyzing, and interpreting love to theologians on the one hand and to writers of scripts for movies, soap operas, popular tunes, and rock and roll music on the other. Love is a feeling; feelings are facts; and facts are the business of scientific investigation. Hence, we shall think together on love in nursing.

It is probably fair to say that no living human being is completely unable to accept love; and no living human being is able to give complete love. Like all feelings, there is variation in the extent to which love is accepted or expressed.

> The need for love is desperate because without love we (would) die. All (persons) since they need love so desperately, demand love of us and demand perfect love; but we demand it of them, too. We cannot meet such a demand, of course, because our own egocentric preoccupation with our need of love finds the love demands of others unwelcome and too demanding[1].

It would appear that perfect immunity from love and, equally, expressions of perfect love are unattainable in human nature. No person is perfectly immune from love because people by nature are dependent. No person can express perfect love because people by nature are self-centred. Because of our need to maintain our integrity, our worthwhileness, and our dignity, we individuals necessarily are self-centred. Self-centredness, of course, is relative. Some persons are more self-centred than others; all are self-centred to some extent. Yet, perfect love is free and unconditional.

A basic assumption in this discussion is that human beings are incapable of expressing perfect love. It is important to recognize this natural limitation. The theologians assert that perfect love is found only in God. Since nurses are not God or even gods, they hardly could be expected to give perfect, tender loving care. The one group in our society most capable of expressing near-perfect love is the family. All of us know that inadequacies and emotional deficits are found in this group. What young parent has not felt resentment, at some time, about the exhausting demands of an infant? Certainly, it is a near-ultimate in self-sacrifice to nurture the helpless baby during all hours of the day and many of the night. What middle-aged parent has not felt rejected, at some time, because of the increasing independence of a teenage child? Certainly, the adolescent, who desires the approval of his peers more than that of his parents, taxes the love and acceptance of the most understanding mother or father. Yes, even within a family group, an imperfect love is found; feelings of rejection and resentment are present.

The fact that the nature of our being and the conditions of our work make it impossible to receive and to give perfect love is no reason for our not loving at all. It is the experience of having been loved and nurtured in a family that has taught us to love and to be accepting of love in return. However, it should not be thought that love is a feeling restricted in its expression to family members only. The world would be in a fix if only family members were in love. Parenthetically, it might be added that love and sex are not synonymous.

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The sexual technique is only an instrument of love; and in some instances, it may be an instrument of hate. In like manner, the techniques of teaching and caring for patients in nursing may be instruments of love, may be instruments of hate, or instruments of some other feelings in between. Dr. John R. Weinlick of the Moravian Seminary in Bethlehem, Pennsylvania, makes these cogent observations on the place of love in social relations. He states that:

> Living together without rules and regulations is unthinkable. But people can never put into their formulated codes all that is necessary for satisfactory human relationships. Even if everybody always stuck to the rules something would be lacking. A group never functions properly without the presence of someone bigger than the rules, someone both generous enough to do more than the rules call for and magnanimous enough to renounce what the rules entitle him to[2].

These observations, of course, apply to all human groups — work groups such as the two person nurse-patient group as well as the family group.

Love, therefore, is the feeling that enables one both to give and to take according to the requirements of the situation. Historically, the helping professions have recognized the importance and the necessity of giving. Our stereotyped picture of the nurse is that of a person who gives without thought of self or reward in service to mankind. We have traditionalized and romanticized this concept of nursing since the days of Florence Nightingale. Today, however, it is asserted that *the ability to receive from others is of equal importance in comprehensive nursing care.* If nursing is seen as a helping profession rather than as a giving profession, the nurse must learn how to give and how to terminate giving at the appropriate time.

Again, we may use the family as an analogy. Most parents know that if they give a dependent child too much, too long and too often, the dependent offspring may be hindered rather than helped in his growth and development. They also know that the child's struggle against dependency is essential if he is to become an independent, self-directing adult. If the patient is to mature and grow out of his dependency status and if the nurse is to mature and grow into her helping status, each must be afforded the opportunity to give. In providing an opportunity for the patient to give, the nurse has to receive.

Doing for patients what they cannot do for themselves, giving to the weak from our own strength, is tremendously satisfying to our picture of ourselves as devoted servants of suffering humanity. But, when nursing involves giving only, there is little or no love in the nurse-patient relationship. In this kind of situation, the nurse is apt to fulfill her own need to give without considering the patient's corresponding needs to receive and to give. When a compulsion to give is the dominant motivation associated with nursing activity, the techniques of nursing are liable to be the instruments of insecurity, hostility, guilt, or some feeling other than love. The compulsion to give, so characteristic of persons in the helping professions, is idealized in the cultural values of our society. In the days of our youth, most of us learned that it is more blessed to give than to receive. This cultural value serves as a shield behind which the nurse and her colleagues in the helping professions may become tyrants of giving and by being unable to receive as may be necessary. There are always gross inadequacies in any tyrannical relationship whether the tyrant be a benevolent nurse, doctor, industrialist, or politician. The ability to recognize the patient's changing needs and to appropriately modify one's giving or receiving behavior according to requirements of the situation is possible when nursing is motivated by love rather than by a compulsion to give. Affording the patient the opportunity to give is essential to the maintenance of his self-respect.

At an Annual State Conference for Health Officers Dr. Joseph J. Downing, a psychiatrist, told the story of a public health nurse who felt that she was wasting her time in continuing to visit an older woman who had made a fairly good recovery from her illness and was convalescing. The elderly woman who lived alone wanted the nurse to continue to make periodic calls. The nurse felt that she could no longer justify carrying this patient in her case load because, "there is nothing that a nurse can do except listen to the old woman talk."

At this stage of the patient's recovery, the ability to accept verbal communication from the patient may have been a technique of therapy as important as the ability to administer medication during the period of acute illness. After all, one of the goals of medical therapy is to help the patient to maintain a state of homeostasis. Homeostasis is achieved when there is adequate integration within each system and adequate coordination between different systems. Comprehensive nursing care, motivated by love, is cognizant of the psychic, the social and the cultural systems of life as well as the biological system and attempts to meet the demands of them. In the case of this convalescing older patient, it may have been more blessed to receive than to give.

As chronic illnesses rise and as the numbers of geriatric patients expand, the importance of consciously relating to patients in a receiving role will increase because of the lengthened process of convalescence and recovery. The temptation to permit the patient to fixate at a certain level of dependency is ever-present with the therapist. The danger of this temptation is heightened because of the extended period of interaction required between the therapist and the chronically ill patient. At an Institute on "Caring for Older People Today and Tomorrow" sponsored by the Council on Aging in Syracuse, New York, Dr. Leo Jivoff of the Veterans Administration Hospital made the following statements:

> To rehabilitate handicapped patients requires relating to them in a different way than one usually relates to a patient in a general hospital. For example, rather than turning the patient, the patient should be encouraged to turn himself. One has to learn not to support a patient who needs to try to walk by himself. And one has to learn how to take that extra thirty seconds with a patient having difficulty in talking so that the patient will make the effort to get words out.

These statements by Dr. Jivoff and the story of the old woman and the nurse point up the importance of attenuating the giving techniques of nursing in some situations.

In recent years, the nursing profession has increasingly utilized the findings of the social sciences. For example, it is a principle of medical psychology that sick people tend to regress and become childlike in their wants and desires, and in their ways of interacting with others, including the nurse. Since childhood is a dependency state and a time when we receive from more persons than we give to, nurses expect patients to be dependent. They define the patient's role as one of receiving. This psychological finding pertaining to regression and illness has been of great value. Knowledge of this principle has enabled the nurse to understand the immature behavior of her adult patients.

This principle, of course, neither applies to all patients nor to all periods of the patient experience. Although the adult patient may act in a childlike manner, it is important to remember that he is not a child. As recovery ensues and growth toward regular or maximum strength continues, the individual — though still a patient — must be related to in a different way. While at one time it may have been necessary for the nurse to give of herself to accommodate the patient's regression, at another point on the scale of recovery it may be necessary for the nurse to receive of the patient to accelerate growth and progression. Hence, knowledge of the principles of illness and regression should be supplemented with information on growth and expression. Giving is an aspect of growing.

This business of receiving is not a commonsense approach to caring for patients. It is a technique of nursing which requires the highest type of professionalization for effective implementation. The nurse as a therapist is called upon to receive from the patient as though she were dependent; and yet, she must not lose control of the situation or really regress to an immature status. In the act of receiving from the patient, if the nurse should regress and really need to be cared for, her nursing behavior would become inadequate, for she would be fulfilling the required roles of a nurse only in part. Although the patient may assume the role of therapist, this is a temporary and transitory occurrence. Disability due to his physical or mental problem as well as insufficient training make it impossible for the patient to continue in the therapist role for an extended period of time. Hence, the technique of receiving from

patients to encourage their recovery requires that the nurse should depend on and yet not become dependent, that she should accept like a child and yet not regress to a childlike status. One does not come by techniques like these by simply applying commonsense to the nursing situation. To effect the illusion of being while not being requires a discipline and an imagination of the highest professional type.

There is probably a desire to be a patient in every nurse and a desire to be a therapist in every patient. The general outlines of this thought are presented in a book entitled *The Roots of Psychotherapy* by Dr. Carl A. Whitaker and Dr. Thomas P. Malone[4]. Some nurses have not come to terms with their patient desires. The nurse may attempt to repress these desires in herself or she may become ashamed of them when they inevitably appear. It is not unnatural for a nurse to want to be cared for, to want someone to look after her, to want to be consoled. Many nurses have experienced these patient desires at one time or another. In like manner, some nurses have not come to terms with the therapist desires in their patients. The nurse may attempt to suppress these desires in the patient or she may become resentful of them when they inevitably appear. The therapist desires in the patient are usually veiled. They sometimes appear as inquiries into the nurse's personal affairs. These are the patients who may offer advice on matters pertaining to money, marriage and life in general. Actually, this may be an attempt by the patient to become the therapist which is not an unnatural desire.

In most instances, the nurse follows her culturally prescribed roles and behaves as a nurse is expected to behave; and the patient does, too. But the presence of these latent needs in both nurse and patient should be recognized and accepted if they are to be dealt with and controlled in a mature and adequate way. The nurse who does not recognize her own desire to be a patient and the desire of her patient to be a therapist may agonizingly struggle to impose and enforce the culturally sanctioned roles of nurse and patient at all times and at all costs. When she finds that her inappropriate efforts are futile, she may think of herself as a failure, as one unsuited for nursing; or she may employ the technique of withdrawal sometimes called defensively "objectivity." The efficacy of this technique has long since been debunked, according to Doctors Whitaker and Malone. They go on to say that ". . . a schizophrenic withdrawal is the most universal mechanism for adapting oneself to the anxieties elicited when one is precipitated into deeply symbolic human relationships." Although the authors make their statements primarily with reference to psychotherapists, it is clear that these conclusions may apply also to nurses.

Does the feeling of love have an effect upon these circumstances? Of course it does. The unconditional quality in love enables the nurse to accept herself and the patient when either may deviate from expected behavior. The presence of love enables the nurse to accept herself as a necessarily imperfect exponent of human nature — most of the time doing good, some of the time making mistakes, and often times needing help. Acceptance of the desire to deviate from the culturally prescribed roles of nurse and patient, and acceptance of the actual reversal of these roles for brief periods, may cause the experience, an inevitable experience, to be less frustrating to the nurse. During a period of crisis, one is better able to mobilize her energies to guide the nurse-patient relationships back to the required pattern of interaction.

Most of this discussion has been focused on the nurse who comes in direct contact with the patient. Our analysis of the situation would be faulty were we to expect the nurse to read these words and to go forth and forevermore put love in her nursing. The nurse must be seen as a member of a larger organization. Her behavior, in part, reflects the nature of that organization. What I am trying to say is this: "The ability to love is always the result of having been loved." If there is to be more love in nursing, then the responsibility also falls on the supervisors of services and the administrators of agencies. Having received love from them, the nurse is better able to love her patients. The sources of love are many: from her parents and patients, from her mate, date or associates the nurse may receive love. As important as these sources are, still they do

not substitute for supportive supervision and appreciative administration in the work situation.

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In Memoriam

Dorothy (Dinwiddie) Bell who graduated from Women's College Hospital, Toronto in 1928 died on October 20, 1957. For many years she had been the assistant director of nurses.

* * *

Mary Catherine Crane, a graduate of St. Joseph's Hospital, Hamilton in 1920 died on October 26, 1957. Miss Crane was on the staff of the West Lincoln Memorial Hospital, Grimsby, Ont. at the time of her death.

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Mrs. Agnes Corr who graduated from St. John's Hospital, Lowell, Mass. in 1939 died in Saint John, N.B. in March, 1957. She was engaged in private nursing at the time of her death.

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Mary E. Davidson who graduated from Nicholl's Hospital, Peterborough, Ont. in 1910 died suddenly in November, 1957. She had served overseas with the C.A.M.C. at Taplow, England during World War I.

* * *

Mrs. Vera Fulton a graduate of Fisher Memorial Hospital, Woodstock, N.B. in 1928 died in May, 1957 at the Carleton Memorial Hospital, Woodstock. Following graduation, Mrs. Fulton did private nursing prior to accepting a position as night supervisor.

* * *

Mrs. Edna F. Guthrie, a graduate of Garfield Park Hospital, Chicago in 1926, died in 1957 at Welland, Ont.

* * *

Ferne Lydia Hitchcock, a graduate of Soldiers' Memorial Hospital, Campbellton, N.B. in 1945, died during 1957.

* * *

Alice (Jenking) Rogers who graduated from Royal Victoria Hospital, Montreal in 1912 died in Lachine, P.Q., on September 21, 1957.

Lillian M. Jones a graduate of St. Joseph's Hospital, London, Ont. in 1918, died in London in 1957.

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Charlotte LeBlanc who graduated from the Hotel Dieu Hospital, Moncton in 1949 died in the tragic crash of an M.C.A. plane in Quebec in August, 1957. Miss LeBlanc was a stewardess with Maritime Central Airways.

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Freda W. McGrath, a graduate of Roosevelt Hospital, New York, died in Kentville, N.S. on October 9, 1957. Following graduation, Miss McGrath spent a number of years on the staff of her home hospital before coming to the Blanchard-Fraser Memorial Hospital. Latterly, she had engaged in private nursing in Yarmouth.

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Phyllis (Innes) McMillan who graduated from Women's College Hospital, Toronto in 1927 died in Toronto on September 15, 1957. Following graduation Mrs. McMillan spent some time with the Victorian Order of Nurses before joining the City Welfare department. Later she engaged in occupational health and private nursing.

* * *

Dorothy Robertson who graduated from Soldier's Memorial Hospital, Campbellton in 1951 died in a car crash in October, 1957.

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Ruth E. Robertson a graduate of St. Michael's Hospital, Toronto in 1943, died on May 23, 1957.

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Henriette Thibodeau a graduate of Hotel Dieu Hospital, Chatham, N.B. in 1952 died from injuries received in a car accident in October, 1957. At the time of her death Miss Thibodeau was on the staff of the Polio Clinic, Fredericton, N.B.

Nursing Today and Tomorrow

CONFERENCES have become increasingly popular, in recent years, as a vehicle for the exchange of information between related but not necessarily closely associated groups. We read frequently in the press of conferences between labor and management; between groups at the provincial and federal levels of government; on the international scene, between small countries and large. In each instance there is general discussion of confronting problems, the presentation of personal points of view and resultant recommendations for action.

The first Canadian Conference on Nursing, held on the campus of the University of Ottawa, on November 4 and 5, 1957, fitted the broad, general description quite accurately. There were representatives of the medical profession and related associations; men conversant with the wide range of hospital problems were on hand as were representatives of the field of general education, and numerous lay organizations. About a third of the group of over 100 were nurses. Showing sparsely or not represented at all were such responsible groups as the legislators and business administrators who need to be made aware of the problems that press in upon us professionally. Their absence was regretted.

This was the first occasion upon which such a conference had been initiated by the Canadian Nurses' Association. Very ably chaired by Mr. Joseph Jeffery, O.B.E., Q.C., of London, Ont., the conference opened and closed with plenary sessions. The intervening hours were assigned as discussion periods when eight groups aired differing points of view and talked their way toward possible answers to problems posed by the CNA.

A doctor, a nurse and a lay woman presented papers to set the stage for the subsequent discussions. The addresses given by Dr. Roth and Mrs. MacLeod follow this report.

On the second afternoon Miss Dorothy Percy presented a summary of the very worthwhile discussions that had taken place in the eight panels. Space does not permit the publication of the separate reports. Miss Percy's summary reveals the close interrelationship that underlay the different problems.

SUMMARY OF GROUP DISCUSSIONS

In reviewing the eight group reports it would appear that most of the points brought out in discussion would fit under one or more of the following headings: *education, finance, utilization, communications and research.*

I. *Education*: There was not one group in which a discussion of some phase of nursing education — either basic or post-basic — was not touched upon at least. Under this heading, also, are included references (of which there were many) to the preparation of the nursing assistant and the need for her inclusion in the "team."

In other words, "education" cut across every area of discussion of conference goals and into the finer breakdown of topics as well.

The conflict between nursing education and nursing service received a good deal of attention and while there was not complete agreement on *where* the nurse's basic preparation should take place, that it should be a truly educational experience seemed to find majority favor.

The need for a larger number of nurses with advanced preparation in special fields was stressed. In this connection, improved selection procedures and increased financial assistance for those taking advanced work were deemed of prime importance.

II. *Finance*: Here again was an area which impinged on many of the conference goals. Much of the discussion centred around the fate of nursing school costs when provincial hospitalization schemes, federally assisted, come into operation.

The need for more precise factual knowledge regarding nursing costs was underlined.

III. *Utilization*: There seemed to be general agreement that there is failure to make the best use of the nurse's time and energy. In this connection, some of

our "shortages" may be more apparent than real. The adoption of improved management skills, streamlining of some procedures, and elimination of other time-honored ones were among the suggestions which might prove helpful in better utilization of what we already have.

Knowing more about what nurses, nursing assistants and others in the team actually *do*, would be of assistance in setting up job descriptions and defining function more realistically. Research is very definitely indicated in this area.

Again, more intelligent use of the team would seem to be one of the answers.

IV. *Communications*: If this Conference had accomplished nothing more than to turn the spotlight on the value of improved communication between the individuals representing various groups and disciplines, it might be said to have "earned its passage."

This importance of good communications was touched on by most of the groups. There seemed to be strong realization that there is a great need to sit down together and discuss mutual problems in an atmosphere of trust, coupled with a desire to understand and to be helpful.

This matter of public relations has internal as well as external aspects. It has also interprofessional and lay-professional connotations which require further exploration.

V. *Research*: New vistas appeared to open out in this area underlining so many ways in which nursing might be helped by both "minor" and "major" research projects. Definition, prerequisite conditions, costs, personnel, etc. were some of the facets of the problem of research which received attention.

One group, in addition to its detailed recording of findings ended up with these words:

1. This Conference should be used as a vehicle for *action*.
2. We have been too cautious and too unimaginative in designing solutions for many of our problems.
3. Many suggested ideas should be vigorously approached and experimentation undertaken.
4. New patterns of nursing education will affect the total picture significantly and should be encouraged.
5. The role of the nurse has been extended into the field of prevention of disease and promotion of health, and new work assignments must be adopted to encompass the new area of responsibility.

Many recommendations for action were received from each discussion group. These were collated into suitable form by Dr. Malcolm Taylor who presented them to the assembly for discussion and vote. The approved recommendations will be referred to the February meeting of the CNA Executive Committee for further consideration.

The recommendations as approved by a two-thirds majority of the active participants at the Canadian Conference on Nursing were as follows:

1. The preparation of the nurse should be an educational experience and the method by which this can best be achieved is through a school which plans and controls the complete educational experience of the student.
2. The budget of a hospital school of nursing should be a separate entity within the over-all hospital budget. Where necessary, budgets should be expanded to enable the schools to achieve recognized standards of nursing education. It is further urged that the budget be interpreted to nursing executives, medical staff, hospital administrators, hospital boards and government at all levels.
3. Because the provision of adequate nursing service is of concern to the public and because of the lack of factual data on which an assessment of nursing service can be made at the present time; research projects should be undertaken by interested agencies directed to, among others, the following objectives:
   (a) The needs of the public for nursing services.
   (b) The types of personnel now engaged in meeting these needs and duties assigned to them.
   (c) The possibilities of re-assignment of nursing duties to existing and new groups of nursing personnel.
   (d) The best and most economic ways of preparing the necessary personnel.
4. There is also need for fundamental research and study in other aspects of nursing service and education and the Canadian Nurses' Association should exercise greater leadership in the launching of such projects.

In addition there is a lack of general knowledge of the findings of past studies. All agencies (schools of nursing, hospitals, and other health agencies) should report and interpret their findings to all groups concerned.

5. Because the critical shortage of nurses with advanced training as teachers, supervisors, administrators, consultants and other specialists is impeding the recruitment and training of more nurses, the Canadian Nurses' Association should investigate methods of expanding the recruitment, selection and training of nurses for advanced studies in these fields. Educational programs for nurses should be established in these fields at one or more Canadian universities on the post-Bachelor level and bursary programs should be expanded to assist individuals to take advanced training.

6. In all planning for nursing education, the preparation of the nursing assistant should be included as an integral part of nursing education.

7. The Canadian Nurses' Association should take steps to improve the liaison on local, provincial and national levels between the Canadian Nurses' Association and the Canadian Medical Association, the Canadian Hospital Association, the Canadian Public Health Association and any other health associations in order to improve the intercommunication and understanding between personnel of the various disciplines.

As a further means of achieving greater cooperation between practicing members of the health team, provision should be made in the curriculum for the preparation of each type of health worker for obtaining knowledge and appreciation of the role of the other members.

8. In view of the greater delegation to nurses of technical procedures formerly performed by the physician, that the pressures of scientific techniques and of special skills and other intricacies of modern therapy should not be allowed to submerge the art of nursing, that is, the constant awareness of the importance of the human relationship in the achievement, maintenance, and recovery of health.

9. In the expanding hospital care program, more attention should be given to the provision of nursing care in the home as a means of achieving more effective use of hospital and nursing resources.

In retrospect, the consensus is that it was a good conference. Its preparation entailed a tremendous volume of work, correspondence, mimeographing, checking and cross-checking. To Miss Lola Wilson, who acted as executive secretary of the conference, goes very great credit for the smoothly functioning arrangements.

Many participants expressed the hope that this was just the first of many similar conferences. Perhaps even more important than the repetition of such a program at the national level would be the expansion of this idea at provincial levels.

M.E.K.

Forty percent of fatal accidents that happen to children between one and four years of age take place in and around the home.

1. Pills containing dangerous substances, but sugar coated to make them palatable, are often left lying about because adults do not realize the risk involved.

2. Small children may chew cigarettes, imitating their elders smoking them, and get nicotine poisoning.

3. As a result of holding frayed electric wires in their mouths children get burns around the lips.

4. Electric points and plugs are fascinating to play with but they are dangerous if they are live.

5. The long handle of a cooking pot on the stove sticks out invitingly and dangerous scalding can happen if the child tips it.

A new paint, manufactured in the Netherlands, absorbs ultraviolet light. It was designed primarily for use in industrial areas where welding torches are in constant use, since it is found that the ultraviolet absorbing qualities of the paint greatly reduce harmful effects to the eyes. It can also be used in hospital rooms where exposure to ultraviolet rays is part of the treatment.

—*Health and Industrial Safety*

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The more you say, the less people remember.

—François Fenelon

A Doctor Views the Problems

F. Burns Roth, M.D.

When I was invited to be one of the persons who would make some introductory comments on nursing problems, I agreed with some misgivings. These arose largely because I felt that to be useful I should have something constructive to say or, alternatively, be so provocative that a spirited discussion would be bound to follow. As I reflected, there seemed to be some fundamental problems which have not been satisfactorily documented, and certainly not solved. By filling in some of the background, immediate problems may then be brought into sharper relief and into better perspective.

The most useful service I can perform may be, therefore, to try to identify some of the more fundamental problems that I see as being associated with nursing. In doing so, an honest attempt will be made to see these from a point of view which is unbiased by any personal viewpoint I may have as an administrator of a health program beset, as we all are, with staff shortages, increased costs and increased service demands.

Nursing, as much as any profession, has recognized that any process of evolution, whether it be technical, social or intellectual, demands a careful watch on the evolving process so that appropriate modifications may be instituted as these become desirable. All of us are grateful for the opportunity which has been given us by the Canadian Nurses' Association to participate in developing a better understanding of where nursing now stands and where we hope it will go.

One cannot help but comment at the outset that many changes have taken place in nursing. While this is a trite and perhaps superfluous comment it must be recognized that these changes are of two kinds — those which are readily apparent and those which are less so. It is these changes, which are often unapparent, ill-understood or difficult to recognize, that constitute a proper field for study, discussion and, eventually, remedy.

I am not at all certain that there is a full appreciation of the changing pattern of nursing and particularly the changing demands being made on nursing and on nurses. To say that some nurses have a clear understanding of the nature of these changes may be true; that all nurses have this understanding is not likely; that the associated health professions have a clear picture of the complex changes which have occurred is quite unlikely; that the public has any concrete understanding of the demands of today is hard to believe.

It therefore seems that one of our fundamental concerns is the elaboration of a better understanding of the exact nature of the changes which are taking place and which are predictable for the future. If we are to study change we must have a reference point from which both retrospective and progressive evaluations can be made. That this reference point should be today's situation is evident.

Today, the physician, the hospital, the public health administrator, the nurse herself and, above all, the patient have quite different images of the nurse and the nursing function. These differences in concept occur not only when dealing with nursing as a generality but also when dealing with any specific area or situation. We are inclined to look at the function of the nurse as related to our own immediate problems. All too often this leads to a superficial approach to a definition of function, the end result being a multiplicity of images of what the nurse is and what she does. One of our prime needs is a generally accepted concept of the role of nursing. It might be expedient to point out some of the differences in concept which do exist.

Dr. Roth is Deputy Minister of Public Health for Saskatchewan. This address was delivered at the opening session of the Canadian Conference on Nursing.

I am always impressed by the seeming differences of opinion which exist as to the exact nature of nursing. It would appear that there is commonly accepted agreement as to the fundamental characteristics of nursing. To paraphrase a statement made by Esther Lucille Brown, the elements of this might be described as a recognition of the total health needs of a person, sick or well; the possession of the necessary knowledge of how to meet those needs and a discriminative judgment which will be able to recognize those needs which can be met by nursing.

Differences of opinion as to function lie in the application of this philosophy. We all know of nurses, physicians, patients and particularly, friends of the patient who reiterate that the sole job of nursing is to give bedside care. One often suspects that these people feel that this care can be rendered without any knowledge of why it is being rendered or of the implications of what is being done. Indeed, one would suspect that these people quite often see nursing as being analogous to pampering the patient; often one would suspect, too, at the expense of the patient neglecting to assume a role of self-support. This group of persons is small but, because they tend to be vocal, their impact is strong. We have all heard their pleas for a nurse whose major skill lies in making the patient comfortable. Comfort has its place but the road back to health is often thorny and hard, and the patient must oftimes be expected to exert great efforts with considerable pain and travail. As we begin to know more about the process of rehabilitation, for example, the importance of constant stimulation of the patient to put forth the ultimate effort to regain maximum function becomes evident. Many of our nursing homes and chronic hospitals are, perhaps, as full as they are today because of misplaced emphasis on the comfort of the patient.

At the other extreme there is a very small group of persons who regard nursing as being merely the exercise of a series of high grade technical procedures, the application of which involves little need for understanding.

The majority of us, whether we be nurses, physicians, patients or interested bystanders, take our stand somewhere between these two extremes, our concepts being molded by our experience, our prejudices, our familiarity and our insight. In spite of the fact that we all claim to hold some part of this middle ground, the breadth of that ground is such as to put many of us far apart.

For just a moment I would like to refer to some of the things which can be extracted from the very broad list — the many facets of nursing.

One of the gaps which needs filling before we can determine the role of nursing is a clear understanding of the needs of the public. I was going to say the needs of the patient but the connotation that ill persons *only* need nursing and health services is too restrictive. Nursing, along with all other health disciplines, must increasingly concern itself about the maintenance of health as against the current preoccupation with the treatment of disease. If we look at our health needs and the demands made for services in the light of what we know, we cannot help being impressed by what we don't know. For the seriously ill patient we have a very good understanding of his physical needs; we can adjust his fluid balance, his metabolic and other physiological processes with considerable accuracy and come very close to achieving an optimum condition. However, when we try to evaluate the emotional and social needs of our patient, we are working in an area which is very poorly understood. We all make differing assumptions as to his needs based to a great extent on a subjective analysis of his problems. Similarly, if we are to render full services to the public, including ourselves as part of it, we must also learn much more about the impact of emotional, social and environmental factors on our ability to maintain a state of healthiness.

There can be no doubt of the need for more precise evaluation of the impact of emotional factors on health and disease. One would hope that more objective measurements and more accurate tools can be devised, inasmuch as the measuring tools that we have are still inadequately developed and poorly understood. We will have to learn to cooperate with the social scientist

to a much greater extent than at present. This will require better understanding on the part of both disciplines of the theories and techniques which are applicable to joint study; it will require, as well, a willingness to co-operate and to recognize that each discipline can be of real value to the other.

It seems to me that the health professions have been rather hesitant about establishing a liaison with the social scientist, but it must be added that the nursing profession has fostered these desirable common interests to a greater extent than have the other health professions. But I would suspect that nurses would agree that they have not gone far enough.

Once we have developed a better knowledge of the physical, social and emotional needs of those with whom we deal we will be able to develop better plans for training, for administration and organization of nursing services. However, we should not use our presently imperfect knowledge as an excuse for maintaining the *status quo* and refusing to make any changes at all. There are many things which we now know about the needs of people and our knowledge is increasing daily. As this knowledge grows, methods of training, organization and administration should also undergo compensatory change.

It seems to me that change will most readily occur if society is aware of the need for change. This is particularly true of those elements of our society who are closely associated with the nursing profession in maintaining health and treating disease. I am quite aware of the many suggestions brought forward by nurses for better methods of organization of nursing education and nursing service. I would suggest that progress toward the goals desired has been slowed by lack of understanding of need on the part of such other closely related agencies and professions as the hospitals, our universities, governments and the medical profession.

One other gap in our knowledge about nursing which I believe needs some study has to do with the motivation of women who go into nursing. Perhaps as important is the apparent lack of motivation for men to enter the field. We must carefully study the reasons why young people wish to enter any profession; more particularly we should study the reasons why they enter a profession which requires as much self-dedication, self-discipline and motivation-for-service as does nursing. Many of our young people have a fundamental desire to render personal service — and by this I mean the kind of personal service which has always been associated with nursing. We have all heard comments made by nurses themselves, by physicians and by patients that somehow nursing has tended to become too technical, too impersonal and too remote from the patient. I am not at all certain that these comments accurately represent the picture today — perhaps they tend to distort the present situation unfairly as most things are distorted when viewed in the perspective of the past. Nevertheless, those of us who have an interest in nursing should look closely at the job we expect the nurse to do in the light of whether this job satisfies the felt needs of the people entering the profession. Whether we can balance the desire for self-expression, for an intimate kind of personal service, with the demands engendered by increasing technological and organizational complexity is a point which deserves much thought. Certainly it will be one of the most difficult tasks ahead in planning for new patterns of nursing education and nursing service. One test which should be applied is the extent to which nurses, both students and graduates, are encouraged to develop a deep personal sense of responsibility for caring for the needs of a person who needs help. In doing so some necessity for a continuity of care follows.

Finally, one of the most important of all gaps in our basic knowledge of nursing is our lack of understanding of what nurses of all types are now doing and the reasons why they should be doing the things they are. Numerous studies are now going on to determine job content. It is safe to say that the leaders in nursing are aware of the present lack of knowledge, are concerned about it and are trying to do something about it. I am not so certain that physicians, hospitals and health administrators are demonstrating an equal awareness or concern.

But I would point out that because of its nature, nursing must be of concern to all agencies and nurses themselves cannot be expected to solve all the problems which exist. A joint attack on filling the gaps in our knowledge is necessary and appropriate.

As I stated at the outset, a deliberate attempt has been made to avoid cataloguing the specific problems which we face. These will come out in our deliberations of the next two days. The problems discussed will likely tend to be specific and intensive. My hope is that they will be viewed as parts of a total problem and that some of the fundamental concerns that I have expressed will be kept in mind when we try to forecast the way ahead.

A Nurse Views the Problems

A. Isobel MacLeod, M.A.

THINKING OVER WHAT I should say on this program, I decided that my best contribution would be to make some personal observations as a director of nursing service and nursing education. I would like to give you as clear a picture as I can of the role of nurses in meeting the health needs of Canadians today and in the future.

Nursing in Canada is influenced by the general philosophy on which health services in this country are based. This philosophy is comprehensive and positive. It sees care during illness as a part of the larger program of health promotion. It sees health as a state of well being, enabling an individual to function effectively as a family member, a worker and a citizen with a reasonable degree of comfort and enjoyment. Health, according to our understanding, also means that the individual has sufficient reserve of physical and emotional strength to meet the times of greater stress experienced from time to time by all people. It sees the health of an individual as an inseparable part of family, community, national and international health.

Isobel MacLeod

Most of the people here know that the scope of nursing includes teaching as well as treating; that it takes place in schools, industrial plants, offices, hospitals and homes; that it serves the healthy as well as the sick and that it influences and is influenced by government as well as private citizens. I am not going to take time to describe in detail the scope of the nurse's service but rather, I will dwell on what I see as the typically nursing functions in all these areas of our health program and will outline some of our most pressing problems in fulfilling these functions.

Having analyzed these functions briefly, I suggest three words which perhaps express best what the nurse does in the broad health program. We

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might say, that she *channels, nurtures* and *interprets.* To accomplish these three basic functions, she uses a variety of skills in technical procedures, human relationships, teaching, supervision and administration.

The nurse channels

The nurse is the final common pathway through which the health services of the community are conveyed to the citizen and focussed in a way which makes them useful to him. She is able to do this because she is in focal position. She is closer to the patient for a longer period than any other professional member of the health team. Frequently during illness, some nurse is at the patient's side 24 hours of the day. The doctor prescribes rest but the acquiring of rest is channelled through the nurse. She sees, through her care of the patient and the environment, that he actually is at rest. She sees that he is physically comfortable, free from anxiety, and that other people around him provide a warm atmosphere free from strain. She applies her knowledge of the scientific principles on which the prescribed treatment is based, modified by her understanding of the patient's needs and capacity as they exist at the time of treatment. In the field of health teaching, the knowledge in the community of an adequate diet is channelled through her and adapted to the family's likes, national and religious customs and financial resources.

The nurse nurtures

She supplies what is necessary when it is needed. She fosters the patient's own physical and psychological resources to fight disease and achieve health. She does this on the physical level through daily hygienic care to maintain optimum functioning of the bodily processes. Emotionally, she supplies, and helps the family and others to supply, an environment which contains a warm personal interest in the patient. She sees that he has the opportunity to be dependent when necessary and to be independent when the time comes. She sees that his questions are answered, his fears relieved and that his courage and self-respect are preserved. She fosters healthy family life by helping members of the family to perform their functions in care of the sick, the young and the old, and to grow together during the crises of childbirth, sickness and death.

The nurse interprets

Because her contact with the patient is close and intimate, she is in a position to be aware of his physical and emotional reactions to his disease, treatment or diagnosis. It is part of her function to assist the doctor and others by keeping them informed of these reactions in the patient. She helps the family to understand the patient's needs and how their behavior affects him. In the industrial plant, she helps management to understand how conditions in the plan affect the workers' health and production. She interprets in the other direction too as she explains to individuals and families, in a way which is meaningful to them, how the doctor, a social worker, clinic or sanitorium can serve them.

The nurse functions as an interpreter in a wider field too. Because of her direct contact with individuals and families when health needs are most evident, she is in a position to be helpful to voluntary and governmental administrative and planning bodies by bringing her experience of these health needs to their attention and suggesting how they might be met. For example, the visiting nurse, through her heavy case load of patients in the older age group who are cared for at home, can give a unique insight into what health services are required to give adequate care to older citizens.

The Knowledge and Skills Required

It is fairly obvious that a nurse must possess technical skills to carry out treatments accurately with maximum comfort to the patient and herself, with safety to both and with economy of time and equipment.

If she is to be able to develop nursing procedures based on principles of medical treatment and to adapt procedures and health teaching to the changing needs of patients, she must have an

understanding of the basic physical and psychological sciences. She must have an understanding of the functioning human being she serves and of the society in which he lives. She requires problem-solving and research skills to study her service objectively and to adjust it to the dynamic society of which it is a part.

A nurse must be sensitive and responsive to the needs of others so she can create supportive relationships with patients, their families and her co-workers.

All nurses must be able to supervise and administer service to some degree and some in the profession must be able to educate student nurses. Some nurses must have skills in business practice. They must be able to draw up a budget and present it with facts which support the planned income and expenditures.

One very important group of skills which is ever more clearly recognized as absolutely essential to a nurse includes those involved in the whole field of communication. She must be able to communicate factual information clearly and acceptably to patients, families, doctors, administrators, board members and others. She must be able to communicate in conversation, in writing, as a committee member. She must be able to communicate as a public speaker and through the medium of radio and television.

A nurse must be able to communicate feelings as well as facts; and along with facts, feelings of warm understanding and courage to her patients. She must be able to communicate sincere conviction as well as respect and friendly acceptance of co-workers in committee work.

It is frightening to see such a formidable list of qualities. How can we expect to find such widely endowed persons in the numbers required? Fortunately *all* nurses do not need to possess *all* these skills in exactly the same way. Perhaps they all require these skills and qualities but some will find they use them better in direct service to patients, families, school children or workers. Others will find they excel in employing these skills in giving direction and leadership or in the teaching of students or in planning with other health workers. Nurses have felt for some time that perhaps there is a need for nurses to function in different areas with different kinds of educational preparation.

Problems Encountered

Our problems fall into two basic areas — to maintain a sufficient supply of nurses giving the quality of care required by the changing needs of society; the education of nurses to perform the functions required of them.

Although there may have been some slight improvement in the number of nurses available in the past few years, the problem of supplying a sufficient number of well qualified nurses will continue to be of great concern. Increasing population, expanding health services and a greater complexity of nursing functions with a need for a more relaxed atmosphere in which nursing care is given, will contribute to this problem. A government plan for hospital and diagnostic services insurance, while greatly to be desired, will no doubt intensify the problem. Is it that we do not have enough nurses, or that their time is not being used to the best advantage? We must think of *both* of these aspects.

There is a need for studies of the way in which nurses use their time, both in the nursing procedures themselves and in the organization and content of the nurses' day. We recognize that it is our responsibility to look critically at the way our time is spent. This kind of evaluation, leading to constant change, will undoubtedly be a continuing process as we find ever new demands being made upon nurses with changing social needs and resources. In our experience thus far, when we analyze how we spend our time, we find, not surprisingly, that in many areas we are dependent upon other people such as hospital administrators, doctors and board members. We cannot help feeling that there must be many of their problems to which we could bring useful information. We ask ourselves if we have fulfilled our role as interpreters and channellers of information, in this larger area. Here are only a few problems of nursing service which might be studied co-

operatively by nurses and other professional and lay workers.

1. There is a need for more resources for care in patients' homes, for the relief of hospitals and for the sake of the patients who under certain conditions are better at home.

2. How can services in the patient's home be financed? Lack of an answer to this question is a great inhibiting factor to developing better hospital-home liaison.

3. What are the actual budget needs of the nursing service? Is the hospital or public health agency allotting too little or too much money to the nursing service?

4. How could communication between doctors and nurses be improved? I believe nurses could carry out prescribed care better and further the recovery of their patients more effectively if they could work more closely with doctors in planning patient care. Nurses would receive more satisfaction from their work. I wonder if doctors would too?

5. How might orders for common procedures be streamlined to save time which could be re-employed in better service?

6. How could the needs of patients and their families, doctors and nurses be more satisfactorily reconciled in hospital admission and discharge regulations?

7. How well are the patient's total needs being met in our hospitals and public health agencies? I think particularly of the geriatic patient and others with long-term illness. Could the practices relating to meal service, recreation and visits be adjusted to serve them more adequately? Could we do more in group teaching and group therapy for the medical and surgical patient?

8. How well are nurses' needs for satisfaction being met? This is significant for two reasons.

a. Nursing is fundamentally a *mutual* relationship. If a nurse is to have the capacity to meet the total human needs of her patients, she must in turn receive satisfactions which meet her needs in a working relationship within a cohesive, mutually supportive team.

b. Work satisfaction might make some contribution to solving the present problem of the great mobility of nurses. Mobility of the worker seems to be a problem throughout society today. Industry is facing the same problem and some are studying the satisfaction or lack of satisfaction their workers receive, believing that greater enjoyment of their work might help workers to settle down. There is a larger social problem here which must be studied by many community groups, such as industry, councils of social agencies and nursing. Some administrators are finding that workers are restless when basic human needs for satisfying, constructive relationship with co-workers, in creative activity are not met fully enough.

Is this a problem in nursing? Are too many of our general staff nurses trying to nurture the patients' resources while functioning themselves at a relatively low level of healthy relationships. How can we supply enough opportunity for the nurse to work in closer companionship with the doctor and others in contributing to the whole plan for patient care?

A nurse, too, must have a satisfying life outside of working hours and this means an adequate place to live reasonably close to the hospital. Why does a happy, constructive senior student too often lose so much of her zest in her work shortly after graduation? Perhaps she misses the camaraderie supplied by her classmates off duty. Suddenly she finds herself relatively isolated and without the amenities for an enjoyable social life. I doubt if the answer is to be found in a return to the same kind of residence life she had as a student, but what is suitable? Is the living accommodation of its graduate nurses a matter of legitimate concern on the part of the hospital?

9. How can we attract and hold desirable young women — and men — to the nursing profession?

10. How can we reach the Canadian people who would like to work with us in planning better health services?

11. How can we use nursing assistants to better advantage?

Problems of Nursing Education

We recognize that schools of nursing must provide, along with technical and scientific learning, planned experiences on the ward, in the residence and community, which will encourage the student's development as

a healthy and socially well adjusted person, capable of independent, creative, and constructive thinking in her own field. It is evident that a nurse uses her personal resources as well as her professional skills in the giving of direct nursing service and in her function as a co-worker with others in planning better care for the sick and better community health services. Our problem is to prepare graduate nurses as quickly as possible consistent with sound educational principles, and as economically as possible to the student and the community. Some excellent studies have been made already in this connection in Canada. Here are some which have been made or are in process:—

Experiments to shorten the nursing course by elimination of time spent in non-educational activities.

Experiments in pooling educational resources and teaching personnel in centralized schools so the short supply of both may be spread as far as possible.

The use of rural hospital affiliation in the education of nurses.

Experiments in sound education for nursing assistants.

There are still other questions which could be answered through cooperative study and planning by nurses and other Canadians who supply and use health services.

This has been a limited and rather general statement by one nurse of the role nurses can play in Canada's health services. It has attempted to define some of the problems we have found in providing nursing service and in educating new nurses. Perhaps we as nurses have been more isolated than we would wish and that we seek opportunities to cooperate with other Canadians in bringing about better care to the sick, more complete rehabilitation and a higher standard of health in our country.

Conférence Canadienne sur le Nursing

Suzanne Giroux

"Les progrès de la science médicale, la pénurie de personnel infirmier (du moins apparente) et l'extension des services de santé sont autant de facteurs qui ont une répercussion sur le rôle de l'infirmière d'aujourd'hui."

Cette considération semble être le leitmotiv de l'Association des Infirmières Canadiennes. Elle a certainement motivé la tenue de la Conférence d'Ottawa, les 4 et 5 novembre 1957, réunissant des membres de la profession venus de toutes les associations provinciales, les sous-ministres de la santé des dix provinces, le sous-ministre de la Santé Nationale et du Bien-Etre ainsi que des directeurs d'hôpitaux, de sociétés médicales et des délégués de sociétés diverses représentant le grand public du Canada.

Cette conférence avait été préparée avec soin. Un questionnaire avait été envoyé aux associations provinciales afin de connaître ce qui avait été fait dans leur province respective, depuis l'enquête faite par le Comité technique d'enquête sur les services de santé (1949-52), concernant l'exécution des recommandations faites au sujet des infirmières. C'est donc avec connaissance des faits que l'A.I.C. pouvait demander à ses invités d'étudier la situation actuelle de la profession.

Dans les préliminaires, trois conférenciers se firent entendre. Le sous-ministre de la Santé de la Saskatchewan, déjà au courant des problèmes de l'assurance-santé, établie dans sa province, tenta de déterminer quelques problèmes auxquels notre profession doit faire face.

La profession d'infirmière, comme toute autre profession, semble reconnaître que l'évolution, soit-elle technique, sociale ou intellectuelle, doit être surveillée avec soin afin d'y apporter les modifications qui peuvent s'imposer.

Les changements qui se sont opérés

Mlle Giroux est visiteuse officielle pour les écoles d'infirmières françaises de la province de Québec.

Photo par Newton-Ottawa

De gauche à droite: M. J. JEFFERY, MME ISOBEL MACLEOD, DR F. B. ROTH

chez les infirmières depuis quelques générations sont de deux natures: les changements apparents et ceux qui ne le sont pas. Les services qui sont requis des infirmières, de nos jours, sont loin d'être connus du grand public.

Tout le monde semble se faire une image différente de ce que doit être l'infirmière et des fonctions qu'elle doit remplir: demandez à un médecin, à un administrateur, à une directrice de service de santé et à une infirmière. Trop souvent l'on se contente d'une analyse basée sur un besoin immédiat.

Nombreux sont les gens (et leur voix est puissante) qui ne voient dans l'infirmière qu'une personne pouvant les gâter en leur donnant tout le confort possible. Par contre, il y a un petit groupe qui ne voit dans l'infirmière qu'une technicienne de haut calibre.

Quels sont donc les besoins du public en matière de santé auxquels l'on doit répondre?

Il semble nécessaire d'exposer ces problèmes avant de déterminer le rôle de l'infirmière. Les infirmières font certainement partie de l'équipe chargée du maintien de la santé tout comme elles ont un rôle à jouer dans le traitement des malades. L'on comprend bien les besoins physiques du malade mais est-on en mesure de répondre aussi à ses besoins psychologiques et sociaux? C'est là une question à étudier avant de déterminer des plans concernant la formation du personnel infirmier, l'administration et l'organisation du service du nursing.

Espérons qu'une des réalisations de cette conférence sera une meilleure compréhension mutuelle et une parfaite connaissance des besoins actuels et des raisons qui peuvent motiver des transformations.

Une autre question importante qui ne semble pas être comprise est la suivante: Pourquoi ne peut-on pas laisser donner tous les soins indifféremment par toutes les catégories de personnel que l'on rencontre dans les hôpitaux?

Ces questions, aussi pertinentes que nombreuses, trouvèrent, en quelque sorte, une réponse sommaire mais juste dans l'adresse de Mme A. I. MacLeod, directrice du service du nursing au Montreal General Hospital et directrice de l'école d'infirmières de cette institution. L'expérience qu'elle a déjà acquise en hygiène publique et ses fonctions actuelles dans un hôpital et à l'école d'infirmières la désignent bien pour exposer à l'assemblée ce que les infirmières cherchent à réaliser.

La profession d'infirmière est influencée aujourd'hui par la philosophie sur laquelle sont basés les services de santé de notre pays: philosophie compréhensive et positive. Le soin des malades est une partie d'un vaste programme ayant trait à la promotion de la santé.

La santé est considérée comme un état de bien-être permettant à un individu de remplir son rôle comme membre de la famille, de la société, travailleur et citoyen, avec un confort et une satisfaction raisonnables. La santé, à notre point de vue, comprend chez l'individu une réserve suffisante de forces physiques et mentales pour lui permettre de faire face aux épreuves, au surmenage que tout homme rencontre au cours de sa vie. La santé d'un individu est liée à celle de sa famille, de son village, de son pays et du monde entier.

Le rôle de l'infirmière comporte aussi bien l'enseignement que les soins: à l'école, dans l'industrie, dans les bureaux, dans les familles et à domicile. Toutes les fonctions de l'infirmière pourraient se résumer par ces trois verbes: Canaliser — entretenir — interpréter.

Canaliser: L'infirmière fait connaître à l'individu les services de santé de sa communauté et lui apprend comment ils peuvent lui être utiles. C'est l'infirmière, du fait qu'elle est la personne le plus directement et le plus constamment en relation avec le malade, qui est le plus en mesure de faire connaître les besoins du malade. C'est elle qui exécute les ordonnances du médecin. Par les soins qu'elle donne et l'atmosphère que crée sa présence, l'infirmière établit un climat de confiance.

Entretenir: Par ce mot, nous entendons entretenir la santé physique et mentale en répondant à tous les besoins sanitaires de l'individu et de la collectivité. Entretenir la santé en prévenant la maladie par tous les moyens à notre disposition. Entretenir les forces physiques et psychiques du malade pour lui permettre de combattre la maladie et recouvrer la santé: sur le plan physique, en donnant quotidiennement les soins hygiéniques permettant un meilleur fonctionnement de l'organisme; sur le plan psychique, en remplaçant et en aidant la famille du malade et en assurant à ce dernier le réconfort moral dont il a tant besoin.

Interpréter: Le contact direct et continu de l'infirmière avec le malade la désigne bien pour ce rôle. Elle a le devoir de communiquer au médecin les réactions de son patient d'informer la famille des besoins et du comportement du malade. Dans l'industrie, elle collabore avec l'administration en expliquant comment les conditions de travail peuvent affecter la santé des travailleurs et, conséquemment, la production. C'est encore l'infirmière qui dira à la famille comment le médecin, l'assistante sociale, l'hôpital ou le sanatorium, selon le cas, peuvent lui rendre service.

Ce triple rôle exige de la part de l'infirmière, en plus des soins physiques qu'elle est appelée à donner au malade, des connaissances en sociologie et en psychologie. Elle doit être capable d'observer de façon précise les situations ou conditions physiques et affectives qui influent sur la santé et communiquer ces observations aux autres membres de l'équipe sanitaire dont elle fait partie: médecin, autres infirmières, administration, famille, etc. Elle doit pouvoir faire ces rapports verbalement, par écrit et en comité.

Toutes les infirmières ne possèdent peut-être pas toutes ces qualités, du moins dans la même mesure. Quelques-unes excelleront dans l'art de donner des soins aux malades, d'autres dans l'organisation des services ou dans la direction du travail, d'autres enfin dans l'enseignement aux étudiantes infirmières mais toutes doivent avoir une certaine connaissance de ces divers domaines de la profession.

Selon Mme MacLeod, des études devraient être faites sur les questions suivantes:

A quoi une hospitalière emploie-t-elle son temps? La qualité des soins donnés aux malades. Etude des différents soins donnés par l'infirmière. Quels sont les besoins des malades en fait de soins? Les fonctions de l'infirmière.

Cette question de soins, de services, tant chez les malades que dans la collectivité, amène nécessairement l'étude de la préparation du personnel en conséquence.

Dans le domaine de l'éducation, bien des questions se posent. Le cours d'infirmière peut-il être raccourci en éliminant les travaux qui ne sont pas indispensables à la formation? Peut-on centraliser certains cours et ainsi résoudre

le manque d'institutrices suffisamment qualifiées?

Il serait trop long d'énumérer ici toutes les questions se rapportant à l'éducation mais elles prouvent que les infirmières, si elles n'ont pas trouvé toutes les solutions, n'en ont pas moins bien réfléchi à leurs problèmes.

Les participants à la conférence se divisèrent en huit commissions pour étudier, chacune plus intensément, les questions résumées sous les huit chefs suivants:

1. Les progrès de la science médicale, la pénurie du personnel infirmier, l'extension des services de santé, autant de facteurs qui ont une répercussion sur le rôle de l'infirmière. Les opinions varient sur le rôle de l'infirmière. Quel doit être le rôle actuel de l'infirmière?

2. On prétend qu'on ne fait le meilleur usage du temps de l'infirmière. Comment peut-on employer à un meilleur escient le temps de l'infirmière?

3. Les soins infirmiers actuellement réclamés ne sont pas conformes aux besoins véritables de l'individu et de la collectivité. Comment peut-on déterminer quels seront ces besoins en 1967? Quelle préparation doit recevoir l'auxiliaire en nursing? Quelles mesures de protection sont nécessaires?

4. L'appui financier des écoles d'infirmières est un problème. Le cours d'infirmière doit-il être financé comme ceux des autres professions?

5. Le besoin d'infirmières bien préparées pour l'enseignement, la surveillance et l'administration est souligné, de même que d'infirmières préparées pour les spécialités suivantes: neurochirurgie, salle d'opération et orthopédie. Comment choisir les candidates devant recevoir cette préparation? Comment aider financièrement ces infirmières?

6. Des relations plus étroites doivent s'établir entre la profession d'infirmière et les autres professions s'intéressant à la santé, les organisations de santé, les gouvernements et le public. Comment établir cette liaison, la développer, la raffermir?

7. Les écoles d'infirmières, offrant le cours de base, donne à l'élève une formation et à l'hôpital, les services des élèves. Les écoles d'infirmières devraient-elles être indépendantes? Quelle est la manière la plus efficace et la plus économique de former des infirmières?

8. Un bon service de santé dépend d'un service de nursing bien organisé et d'un personnel bien préparé. La nécessité de la recherche concernant le nursing et l'éducation des infirmières a été soulignée. Sur quels points doit porter la recherche? Comment, à toutes fins pratiques, la recherche peut-elle être financée et comment trouver le personnel pouvant effectuer ces recherches?

Il m'a été donné d'observer le travail de quatre commissions. Deux choses m'ont frappée: la somme d'information apportée par les infirmières membres des commissions et l'ignorance des médecins, des travailleurs sociaux et du public concernant les infirmières.

Après une journée de travail intense, le rapport des commissions fut présenté au cours d'une assemblée générale.

Mlle H. McArthur, en racontant une partie de son expérience en Corée, changea en quelque sorte notre perspective des besoins véritables de l'homme, de la valeur d'un bon service de nursing qui peut être efficace si le personnel est bien préparé et désireux de servir même dans les milieux les plus difficiles.

Les résolutions suivantes furent présentées à la considération de l'A.I.C.

Recommandations

1. La préparation de l'infirmière est du domaine de l'éducation; le moyen par lequel elle peut acquérir cette formation est par une école qui prépare et qui contrôle le programme éducationnel de l'étudiante.
2. Le budget de l'école d'infirmières, attachée à un hôpital, doit être considéré à part dans le budget total de l'hôpital. Lorsque la chose est nécessaire, les budgets devront être augmentés afin de permettre à l'école d'atteindre les normes reconnues. En plus, il est conseillé fortement d'interpréter le budget, aux infirmières dirigeantes, au personnel médical, aux administrateurs de l'hôpital, au conseil d'administration et aux gouvernements à tous les échelons.
3. Les dispositions nécessaires pour assurer des services infirmiers adéquats sont du ressort du public, actuellement, à cause d'un manque d'informations, il est impossible d'évaluer les services infirmiers nécessaires; des recherches devraient être entreprises par les agen-

ces concernées dans le but de connaitre, entre autres:

a. Les besoins du public en matière de services infirmiers.
b. Les catégories de personnel donnant actuellement ces services et les tâches qui leur sont assignées.
c. La possibilité de confier certaines tâches au personnel existant ou à des nouvelles catégories de personnel.
d. La meilleure manière et la plus économique de préparer le personnel nécessaire.

4. Il est nécessaire que des recherches et des études soient faites sur divers aspects du service du nursing et de l'éducation des infirmières. L'Association des Infirmières Canadiennes devrait exercer une plus grande influence en lançant de tels projets. En plus, il est constaté qu'il y a une ignorance générale des études faites dans le passé. Toutes les institutions (écoles d'infirmières, hôpitaux et autre agences de santé) devraient rapporter et interpréter les résultats de leurs études aux autres groupes intéressés.
5. La pénurie actuelle d'infirmières ayant reçu une formation comme institutrices, surveillantes, administratrices, consultantes ou dans d'autres spécialités s'avère grave à cause de sa répercussion sur le recrutement et la formation des étudiantes infirmières. L'Association des Infirmières Canadiennes devrait étudier les méthodes permettant d'assurer le recrutement, le choix et la préparation d'infirmières dans ces domaines. Dans une ou des universités canadiennes, des programmes d'étude devraient être donnés, permettant aux infirmières de poursuivre des études au delà du baccalauréat et des bourses d'étude devraient être accordées afin d'aider ces personnes à suivre des cours supérieurs.
6. Que dans tous les programmes d'éducation concernant les infirmières, la préparation de l'auxiliaire en nursing soit incluse comme partie du programme.
7. L'Association des Infirmières Canadiennes devrait faire les démarches nécessaires pour améliorer ses relations avec l'Association Médicale Canadienne, l'Association des Hôpitaux Canadiens et l'Association Canadienne de l'Hygiène Publique et toute autre organisation de santé. Il devrait en être de même à tous les échelons, local, provincial et national, afin que les membres de ces diverses disciplines soient mutuellement mieux renseignés et ainsi se comprennent davantage.

   Afin d'assurer une meilleure compréhension entre les membres de l'équipe sanitaire, des mesures devraient être prises pour que soient inclus dans le programme respectif de chaque catégorie, des renseignements sur le rôle des autres membres.
8. Considérant que les médecins délèguent, de plus en plus aux infirmières, des traitements jadis faits par eux, considérant les exigences de la thérapeutique moderne, techniques scientifiques, etc., considérant que ces tendances peuvent faire oublier l'art du nursing, il est recommandé que l'on insiste avec grande vigilance sur l'importance des relations humaines dans l'obtention le maintien et le retour à la santé.
9. Dans le développement des programmes hospitaliers, que plus d'attention soit donnée aux soins à domicile, afin d'employer à meilleures fins les ressources qu'offrent l'hôpital et le personnel hospitalier.

Le président M. Joseph Jeffrey, O.B.E., C.R. souligna le courage de l'Association des Infirmières Canadiennes dans ces termes: "Peu de professions auraient la force de caractère, le courage de dire: il y a quelque chose qui ne va pas chez nous, aidez-nous à le trouver et à y remédier."

Les infirmières ont l'estime et la confiance du grand public mais peu de gens sont au courant de ce qu'elles font et de ce qu'elles désirent faire. Le plus grand défaut des infirmières est peut-être leur manque de communication. La présidente de l'A.I.C. remercia tous les participants de leur présence et de l'aide qu'ils ont bien voulu apporter.

Cette conférence est une étape dans l'histoire de la profession d'infirmière. Elle aura certainement une répercussion. D'autres réunions de ce genre, à l'échelon provincial et régional seraient aussi à désirer. Dans l'intervalle, l'infirmière peut, individuellement, aider à mieux faire connaitre la profession en se renseignant elle-même davantage et en informant son entourage.

Dear Doctor Atlee:

The Balance Between Education and Service

DELLA M. HOWE, B.Sc.N.

THE RECENTLY PUBLISHED article "The Farce of Nursing Education" by Dr. Atlee is interesting and thought provoking. I agree with him when he emphasizes the importance of expert bedside nursing of the patient. However, I do not endorse his views which imply that instruction and supervision to accomplish this end should rest only on the shoulders of the charge nurse.

Does the charge nurse have the necessary time to be the foreman of an inexperienced crew on a busy ward and also have sufficient hours to instruct each student in the details of nursing techniques? Even if she were relieved of paper work and other non-nursing tasks should she not devote most of this time gained to her patients for whom she is responsible? Regardless of the present duties taken away from the head nurse, or the assistance given her, there will still be many times when she will have to make the choice between service and education. Doctors require much of a head nurse's day during the visits to their patients. If a junior student and a doctor needed assistance at the same time the education of the student would probably not get priority from a person with dual responsibility.

Advanced schools of nursing have provided clinical instructors attached to hospital wards to create a proper balance between education and service in the training of a nurse. In addition to the expert instruction and supervision a student can receive from the head nurse in charge of service, she is also entitled to expect instruction and guidance from someone who consistently has time to consider all her needs for education.

The clinical instructor by her close contact with a hospital ward has an opportunity to keep abreast of the progressive techniques and principles practised on that ward and yet is not hindered by the heavy demands of administration. This enables her to impart these advances to her students. Notwithstanding the fact that the position of a clinical instructor is relatively new, and in spite of skepticism, I am convinced hers is the role which can provide the missing link between education and service.

With this in mind, I say the farce of nursing education is that *too few rather than too many good nurses are devoted solely to education.* This is one reason why the full impact of this system of instruction has not been felt. After spending three and one-half years as a clinical instructor in two different hospitals, I have found on a ward with students there are so many opportunities to teach, guide and inspire that I could not imagine having these opportunities interrupted or by-passed because of other duties.

If it is not so out of step to have teaching nurses, what about the problem of straying from practical nursing application? I feel there is no excuse for them permitting this to occur. I, myself, have discovered that teaching student nurses is most stimulating to progress, not only in book knowledge but practical work as well. Nothing prohibits an instructor from performing nursing care and procedures when necessary to keep in touch with today's standards. This falling by the wayside is an individual matter which charge nurses can be guilty of, too.

Is there a danger that a teacher may forget the patient, the most important object of nursing? I have noticed that few teachers do. When working with undergraduate nurses you are closely associated with the patient and thus will find it essential to consider this patient in order to be successful in your instruction.

Mrs. Howe is presently employed as medical clinical instructor at the Regina General Hospital, Regina, Sask.

Do persons not directly in charge of service easily forget the needs of the busy ward? My experience has been that if they do forget they will soon be reminded by the service division. In this age of nurse shortage, teachers learn early in their career that the service function of the student must ever be kept in mind if they hope to get the cooperation necessary in their teaching. Most instructors have worked on the side of service and thus will still have consideration for its needs.

If nurse educators are not so out of date in nursing practice why do we often hear the words "We are not producing the quality of nurse today that we did in former years?" Too quickly education gets all the blame for this when there are other factors involved. Perhaps the most important one is that education departments are frequently expected to do all the instructing and setting of good examples when, regardless of who teaches, the effectiveness cannot be felt unless everyone — including staff nurses and doctors — cooperates in creating desirable attitudes and skills in students.

In addition, nursing is more technical and complicated today so that no nurse is able to be completely efficient in all phases of nursing. This is one more reason why I feel that there should be persons such as clinical instructors, specialized in various fields, ever on call to assist those who need it. The thought has occurred to me many times that even the medical profession could benefit by providing medical clinical instructors to guide internes in making decisions and carrying out procedures such as intravenous infusions, etc.

May I now direct my remarks to teachers, particularly clinical teachers. Many of us ourselves are unsure and faltering in our objectives. Thus we cannot inspire others to teach nor inspire our students. Let us examine ourselves.

Too many are discouraged by the prevalent attitude that we serve no purpose. This attitude arises chiefly because of lack of understanding of what our work can actually entail. Are we doing all we can to gain understanding or are we satisfied to accept, dejectedly, the present feeling towards us?

Secondly, are we at times assuming that we can carry the whole load of teaching ourselves, when we must realize our limitations and solicit the help of all our co-workers? We are planners and coordinators of education but we do not have to carry out all the instructing just as the head nurse does not have to carry out all the nursing because she is in charge of patient care.

For those who have tried teaching student nurses for a short period of time but have left it saying "There is nothing in it for me," I would comment that it must be realized that the fullest grasp of the opportunity for service in this field is not gained until adequate time has been devoted to it.

The task of setting an example and being a leader has its difficulties because human weakness will cause all of us to fail at times. We must use these experiences to improve ourselves rather than to fret over occasional failures.

In comparison with other types of nursing service, teaching is slow, as the influence of something taught today may not become evident until months later. "Pats on the back" do not come as often as in bedside nursing because young girls are generally not as appreciative to learn nursing care as patients are to receive it. I assure you, however, teaching can be a great challenge. We must never lose sight of the patient, the busy hospital ward nor the ability of others to help us reach our goals. We must forget how each event affects us ourselves but see the broader objective of guiding the young student nurse and others towards the rendering of better nursing service.

May I close with a thought that was imparted to be by my director "Teaching is a great opportunity to influence the lives of many, both patient and nurse." Let us ensure that it is a good influence.

But if he does really think that there is no distinction between virtue and vice, why, Sir, when he leaves our houses let us count our spoons. —SAMUEL JOHNSON

Adversity is sometimes hard upon a man; but for one man who can stand prosperity, there are a hundred that will stand adversity. —THOMAS CARLYLE

RESEARCH

Centralized Teaching Program in Saskatchewan

An Evaluation

NURSING SERVICE and nursing education are presently experiencing a period of critical evaluation and experimentation. That we need a greater quantity of nursing service is almost a cliché. In addition, more attention is being directed towards "quality of nursing care." Both are dependent upon the programs of nursing education.

We are familiar with the various experiments in two-year programs currently being conducted in several schools of nursing across Canada. Now, in the report prepared by Miss Lola Wilson, former executive-secretary of the Saskatchewan Nurses' Association, of the Centralized Teaching Program, we are given an opportunity to familiarize ourselves with an experiment that originated to meet a provincial need.

Specifically, the schools of nursing in Saskatchewan found themselves faced with an alarming decrease in numbers of teaching and supervisory personnel plus a rapid turnover in existing staffs. It was recognized that the quality factor in nursing was deteriorating as a result. The situation, a major worry to the Saskatchewan Registered Nurses' Association, had also stimulated concern in the Department of Health and among various medical bodies.

In an effort to ease the situation the S.R.N.A. proposed a plan for centralizing the teaching of the basic sciences. Every school of nursing in the province could participate if it wished and students could thus receive the benefit of instruction of a uniform quality from expert teachers. The scheme was devised originally to meet the needs of the smaller schools who would, understandably, face the greatest difficulties in obtaining staff. However, most of the larger schools expressed emphatic interest and the scope of the plan was accordingly broadened. When the first class was admitted to the Centralized Teaching Program in 1953, eight of the ten schools of nursing in the province were participating.

The question of financial support to put the plan into operation presented a problem at first. Both the then Deputy Minister of Health, F. D. Mott, M.D. and the Director of the Division of Hospital Administration and Standards, F. B. Roth, M.D., expressed interest but they felt that the provincial government could not possibly undertake financial responsibility for the program unless a reasonably accurate estimate of the cost of operation could be presented. It was indicated, though, that in the event of the plan becoming operative, the government could and would continue to finance the costs of the nursing students in respect to maintenance, allowances and other coverage to the same extent as such support was forthcoming to the individual school.

Subsequently, the W. K. Kellogg Foundation was approached and the plan outlined in the hope that the scheme would be of sufficient significance to warrant financial support. On November 18, 1952 the Foundation approved the project. "Thus was born what was then called the 'Centralized Lecture Program for Nursing Students in Saskatchewan.'"

The University of Saskatchewan, Saskatoon, and its southern branch, Regina College, assisted in providing physical facilities and staff. A director was appointed for each centre and a

coordinator was responsible for seeing that teaching proceeded along similar lines in both areas. Additional qualified teaching personnel was drawn from the community as required. Nurse tutors were appointed whose duties included: auditing the lectures given by university personnel; providing individual and small group instruction for the students as required; integrating the teaching so that the students would be guided to see the relationships and the application of the basic sciences to nursing. The tutors did some of the teaching in the program as well. These particular members of the staff have proven to be one of the most essential elements — indeed they have been called the backbone of the structure. Eventually the nurse tutors combined the duties of travelling instructors with their other functions since they were in an excellent position to see how teaching in the basic sciences could best be carried over into clinical experience.

The immediate objectives of the program were:

1. To provide sound, adequate instruction for nursing students in the basic sciences for the preclinical period.
2. To improve the program in nursing education through the basic science preparation and to extend this program into the schools of nursing through the use of a travelling instructor.
3. To establish cost accounting systems for schools of nursing so that ultimately there would be available comparable costs for nursing education in all schools of nursing in Saskatchewan.

Long range objectives encompassed the desire to have *nursing education* recognized as belonging within the realm of *education;* to have public recognition of the need for subsidization of nursing; to extend the program beyond its original area of basic preparation.

In 1954 the need for objective evaluation of the Centralized Teaching Program seemed evident. It was recognized that certain adjustments should be made and that an outside opinion would be most helpful in determining what should be done. Dr. E. Kathleen Russell agreed to do this evaluation and carried it out late in the year 1954. Some of the comments and recommendations embodied in her report are as follows:

> This Program is part of a developing situation in Saskatchewan which cannot be checked. The former nursing school conditions are no longer tenable in a province with the medical and health responsibilities already accepted by this province.
>
> The Program is guided by an administration willing to act immediately, as experience dictates, to strengthen, to correct or to check.
>
> The original objectives have not remained clear enough. In addition to strengthening the science teaching, an effort has been made to offer a curriculum much broader than that given hitherto in the home schools. This has led first, to expectation of the impossible and, second, to an attempt to accomplish the impossible[1].
>
> There is too little recognition of the time limitation of a sixteen weeks' program.
>
> The home schools — at least some of these — have not yet identified themselves with this new development in *their own courses*[2].

Following study of Dr. Russell's report, the necessary steps were taken to implement her suggestions:

> Intensive efforts were made to offer improved courses and at the same time reduce the pressures on the students[3].
>
> There was a noticeable reduction in the amount of instructional time[4].
>
> It was through an institute, held in the fall of 1954, that a real beginning was made towards better understanding of the thorough integration of the content of the nursing science course of the Centralized Teaching Program with the teaching of the whole subject of nursing in the home schools . . . Progress in this area did gradually become evident — a matter of real satisfaction both in the home schools of nursing and at the Centralized Teaching Program centres[5].

With several years of operation behind it, it is now possible to further assess the program — its strengths, its weaknesses and its possible future. Certain difficulties have been encountered but none has proven insurmountable. On the credit side, impartial and experienced observers, including Dr. Russell, have reported that the calibre of teaching is of the highest level — impossible for the home schools to duplicate immediately or, possibly, even

in the future. Of special interest is the fact that the opportunity for the students to learn the bulk of basic nursing science in advance of any contact with the patients has become one of the apparent strengths of the program. Evidence suggests that the students become skilled in thinking through health problems selected from situations familiar to them although they have not had contact with patients at this stage of their career.

The program also demonstrated most effectively that nonsectarian schools and those operated by religious orders can function together, exchange ideas and benefit each other. Very valuable relationships were produced in this respect. Even non-participating schools of nursing requested permission, and were granted it, to appoint an observer to the program in order to keep abreast of developments.

In 1955 the W. K. Kellogg Foundation terminated its period of financial support. The Board of Administration had been planning for the day when this would occur. The decision was made to continue the program in the the light of its success as estimated from the results of evaluation. Ways and means of operation were accepted by the participating schools. A recommendation was forwarded by the Special Committee appointed to review the program to the effect that the plan should be established by statute and thus achieve permanent status. A Bill passed at the 1956 session of the Saskatchewan Legislative Assembly accomplished this.

The diversity of agencies concerned with the problem of nursing education in Saskatchewan can not be depicted more strikingly than in the composition of the Board of Administration as set forth under the Act:

> One representative of each participating hospital, appointed by the hospital:
>
> Two persons appointed by the Board of Governors of the University of Saskatchewan.
>
> One person appointed by the Saskatchewan Registered Nurses' Association.
>
> One person appointed by the Saskatchewan Hospital Association.
>
> One person appointed by The Catholic Hospital Conference of Saskatchewan.
>
> One person appointed by The College of Physicians and Surgeons of the Province of Saskatchewan.
>
> One representative of each other association, institution or agency designated by the Lieutenant Governor in Council as an association, institution or agency that ought to be represented on the board, appointed by the association, institution or agency.
>
> One person appointed by the Minister of Public Health.
>
> One person appointed by the Minister of Education.
>
> The person employed by the University of Saskatchewan as adviser to schools of nursing.

The functions of the board are directed towards making all the arrangements necessary to continue the centralized teaching program. It is responsible for drawing up agreements with schools wishing to participate; for determining the course of studies; for employment of personnel; for provision of facilities and equipment; for maintenance of records and notification of the home schools concerning the progress being made by each student; for arranging with the University Hospital for participation in such programs as may be decided.

The opportunity provided for these agencies to work together in the solution of a common problem has resulted in a greater degree of understanding of nursing by those outside the profession than could have been possible otherwise.

That the program is in its infancy is recognized by no one more keenly than those guiding and directing it. Its future is well-pictured in this paragraph from the Report.

> Whenever plans for the Centralized Teaching Program are discussed, one question persists: How is it going to be possible to strengthen nursing education programs, not just in the first four months, but in the three years during which a student is enrolled in the hospital school of nursing? The logical approach here is to proceed carefully, and to meet most urgent needs first. Beyond doubt, the most urgent need in schools of nursing today (now that the Centralized Teaching Program has solved the problem of good instruction for students in the basic sciences during their preclinical period) is in the area of clinical teaching. Prepared clinical teachers

are insufficient in numbers and too few are entering this field. Full recognition is seldom accorded the clinical teacher in the total educational program. Too often there is failure to recognize that this person belongs to the educational program and should not be be carrying on administrative and service duties on the wards to which she is attached. More intensive interpretive efforts concerning the role of the clinical instructor must be carried to the members of the hospital staffs and to all those attached to the staffs of schools of nursing.

REFERENCES

1. Wilson, Lola: The Story of The First Three Years, 1957, p. 64
2. *Ibid* p. 65
3. " p. 43
4. " p. 44
5. " p. 45
6. " p. 76
7. " p. 60

In the Good Old Days

(*The Canadian Nurse* — JANUARY, 1918)

The election came and went. It was rather a surprise to many to see the business-like way in which the women worked and the complete instructions given to the new voters so that there were very few ballots spoiled. To all Canadian women it means another responsibility along with the new privilege.

* * *

For the first time in history dentistry has become a distinct factor in the care and treatment of the army in the time of war. Wonders have been done in the treatment of gunshot injuries of the jaws.

* * *

It is stated that if all fresh fruits were eliminated from the diet one-third of the sickness incidental to childhood and early life would cease. The orange is the most injurious. The evil lies wholly in the pulp, the juice being harmless. This is only the case when the fruit is eaten fresh from the tree. Next in order of unwholesomeness is the peach, apricot, plum and cherry.

* * *

The New York State Department of Health called attention to the fact that automobiles killed more people in that state during the first nine months of 1917 than died from typhoid and scarlet fever combined.

* * *

As the reports of the disaster in Halifax come in, the horror of it is increased. It seems a most opportune time to form among the nurses some organization similar to the American Red Cross which would be equipped and ready at a moment's call. We cannot use the Red Cross since we are affiliated with the British Red Cross which is limited in its field of work to war purposes.

National Health Week, February 2-8

Do we still need a National Health Week? Consider these health facts:

Infant Mortality — Canada still ranks *eleventh* among the nations in infant mortality.

Accidents — More children in the 5-14 years of age group die by accidents than by all 8 principal diseases combined.

Dental Care — The use of fluoridated water would prevent as much dental disease as the total number of dentists now in Canada are able to treat. Only 35 per cent of the Canadian population receive dental care of any kind in any one year.

Mental Health — There are more hospital beds occupied by the mentally ill at any one time in Canada than by patients suffering from all other types of illness taken together.

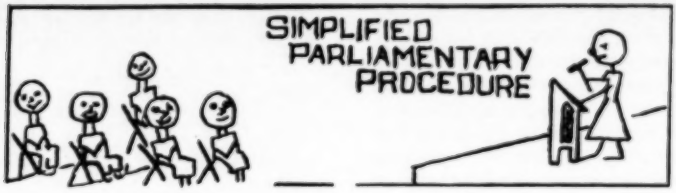
You shouldn't say it is not good. You should say you do not like it; and then, you know, you're perfectly safe.

—JAMES MCNEIL WHISTLER

It's better to give than to receive, and where advice is concerned, it's easier.

* * *

A careful worker is the best safety device.



A Discussion of Principles

All over our land groups of nurses meet regularly to conduct the business of their association. Whether it is as large a body as the Canadian Nurses' Association assembled in convention, or as small as a little rural chapter, it is essential that certain rules of procedure, certain methods of transacting the business should be followed in order to help the group make up its mind on a course of action.

Many nurses learned some of the fundamentals of parliamentary procedure through their participation in Junior Red Cross meetings in public school. Others have belonged to clubs or societies during high school. Most of us have given lip service to this method of securing agreement without knowing too much about the why's and wherefore's of it. This series of brief articles will endeavor to explain the techniques and rules that have been evolved on the basis of a few principles that are very familiar to most of us because we have lived with them all of our lives.

John Foster Dulles has said: "Parliamentary procedure is democracy at work." What then is "democracy"? It is "government with the consent of the governed, limited only by the fact that the laws and circumstances of the governed must accord with the wishes of the majority as expressed through the vote." Let us look at the principles that are basic to our democratic way of life.

Principle I ensures that *the vote of the majority shall decide*. A majority is a number greater than half of any given number of persons voting. Thus, one vote over the half is sufficient to declare a majority. Ordinarily, the presiding officer or chairman does not vote excepting in the event of an equal number of votes for and against a motion. Then, the one vote of the chairman will provide the essential majority and a definite decision can be reached.

When the majority vote is announced, that vote *becomes the decision of the whole organization*. Those who vote against the motion have the same obligation to accept the decision and abide by it as those who vote for it. That is democracy in action.

The organization must have a clear definition of how the majority vote is to be reached. Is it to be 51 per cent of the total membership, of the members present when a vote is taken, or of the members actually voting? While it is always the right and usually the duty of every member to vote upon every question, no member can be compelled to vote. If 25 members are present at a meeting, for example, and only 15 vote, the vote of eight members will establish the decision.

Principle II confers upon all members *equal rights, privileges and obligations*. Every member has a right to bring up points of business, to make motions, to discuss, to ask questions, to nominate and to vote. The rules of the organization may limit the length of time any member may speak or the number of times she may speak on any particular piece of business. If this provision is made in the rules it prevents any single member from dominating all the discussion — sometimes a wise precaution. The chairman must be strict and impartial in applying this and all other rules.

Principle III provides that *the minority has rights which must be protected*. On certain decisions, therefore, a two-thirds or a three-quarters vote may be required. It should be clearly stated in the by-laws governing the association what number of votes will be required to reach decisions on certain matters of business. Perhaps the best known such provision concerns amendments to the constitution and by-laws of the organization. Other ques-

tions on which more than a simple majority vote may be required might include:

(a) Major financial decisions, such as the annual budget, raising fees, the purchase or sale of property.

(b) Dissolving the organization.

(c) Expelling members from the organization.

The right to oppose any question is a precious privilege that must be jealously guarded. The opposition has as much right to present points of view, to discuss and to be heard as those favoring a question. However, once a majority decision has been reached, the organization speaks with one voice. It is childish and quite undemocratic for the minority group to refuse to accept their obligation to abide by the decision.

Principle IV insists that *the simplest and most direct procedure should be followed* to arrive at a common purpose. If a member attempts to confuse an issue by proposing circuitous amendments, it is the duty of the chairman to declare such tactics out of order and indicate the straightforward path that must be followed.

In the interests of the orderly conduct of business, *only one question can be considered at one time.* Several kinds of supplementary motions may be made, all of which will be discussed in later articles in this series. Each of the additional motions must be germane to the main topic being discussed, that is, they must be related or appropriate.

Principle V is a guide to the harassed chairman who is steering the discussion. *Motions have a definite and logical order of precedence* based on the relative importance or value of each motion to the efficient conduct of the business. Members have a right at all times to know how the discussion is going so care must be taken to avoid folksy little conversations between the chairman and the members in the front row. The question to be voted upon must be kept before the entire assembly. Members should also be aware of the effect of a positive or negative vote before being called upon to make a decision.

Principle VI protects the rights of all members of the organization by requiring that *those to whom power is delegated must be chosen by democratic processes.* Power is delegated to committees, to boards, to officers, to individual representatives. Very often the president is given authority to make the appointments but this very authority is accorded to the president by majority vote and can be controlled or withdrawn at the will of the majority at any time.

Without this principle, there would be risk of self-appointed officers or self-perpetuated boards either of which would defeat the whole democratic process. The best safeguard is the inclusion in the bylaws of provision for the election of officers by ballot.

Succeeding articles will discuss such topics as drawing up a suitable agenda, the writing of minutes, the presentation of motions and the rules governing them, methods and procedures of voting, the duties of the officers, the responsibilities of committees, the handling of reports, etc. As the series progresses, readers are invited to submit vexing problems which will be dealt with through these columns.

Next month, **Order of Business.**

CANADIAN NURSES' ASSOCIATION NATIONAL OFFICE

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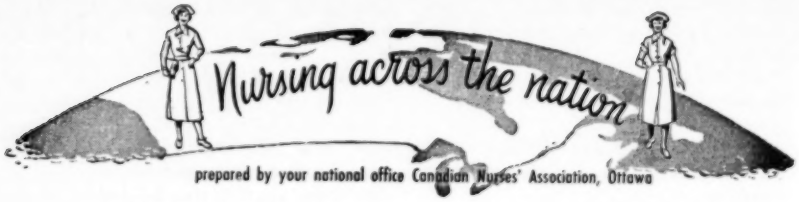

A.P.H.A. Annual Meeting

November 11 to 15, 1957, marked the 85th Annual Meeting of the American Public Health Association. The 4,239 public health workers registered for this convention attended sessions on medical care, maternal and child health, public health nursing, school health, dental health, food and nutrition, public health education and numerous other section meetings.

Those familiar with the APHA and its executive staff will be pleased to know of the moving tribute paid to the late **Dr. Reginald M. Atwater**, for 22 years executive secretary of the APHA. Dr. Atwater's sudden death in mid-October saddened all public health workers. During the presentation of the Lasker Awards — a special award for public administration was given to Mrs. Atwater as recognition of the invaluable contribution rendered by Dr. Atwater in the field of public health.

The citation read in part —

> As teacher, local health commissioner, consultant, editor, Association executive and in many other capacities Reginald Atwater made full use of his keen intellect, his perseverance and his personal charm to do jobs of ever-increasing complexity and importance. Probably there are no leaders in our field in this country who have not profited by his inspiration and guidance; myriads of public health workers in other lands have felt his influence for good.

Dr. Berwyn F. Mattison, due to commence duties as assistant executive director in January, 1958, has now been appointed executive director, effective this month. Dr. Mattison, an American, is a graduate in medicine from McGill University.

Health workers from all parts of the United States and from many parts of Canada participated in the interesting and varied sessions.

Of special interest to public health nurses was a luncheon in honor of Miss **Pearl McIver**, recently retired chief, Public Health Nursing Services, Department of Health, Education and Welfare, U.S. Public Health Service. Five of Miss McIver's former co-workers reviewed her activities in public health nursing and paid tribute to her achievements internationally as well as on the "home front."

Canadian Conference on Nursing

Elsewhere in this issue you will read about the first Canadian Conference on Nursing held by the Canadian Nurses' Association in November 1957. The report of this conference is available at 75 cents per copy from the Canadian Nurses' Association, 270 Laurier Avenue West, Ottawa, Canada.

The addresses, reports of discussion groups, recommendations and list of participants are included in the report. Write now for your copy.

Maybe We're not Indispensable

In looking through the *World Mental Health Journal*, an article entitled, "A Hospital Without Nurses" (Vol. 9, No. 3, pp. 119-122), caught the eye. True enough! In Tuzla, a town of 40,000 people (Yugoslavia), the problem of nursing staff in the pediatric department of a modern 1,000-bed hospital was solved by admitting mothers to care for their own children. The **2** or **3** nurses assigned to this department do the complicated treatments, give medicines and teach the mothers. "The only people who are devoted to looking after the sick children are their mothers." The total nurse complement for this 130-bed department is 6, 3 on morning shift, 2 on afternoon, and 1 at night.

The article goes on to point out the advantages of such a program. In brief they are —

Helps solve the nurse shortage problem.

Is an educational experience for the mother which she is able to put to good use when she returns home.

Makes possible an earlier discharge of the child.

Most important, it helps solve the emotional needs of the children which have a direct bearing on their physical recovery.

The article closes by saying — "Mother-love as a medicine for organic diseases presents a problem which still demands research."

The Program Takes Shape

Latest addition to our list of guest speakers at the CNA 50th Anniversary Meeting is Miss **Agnes Ohlson**, president of the International Council of Nurses. Miss Ohlson is also president of the American Nurses' Association. She will participate in a session concerning nursing in the international field. It will be a pleasure to welcome our ICN President to our meeting.

We have high hopes that Miss **Lyle Creelman**, chief, Nursing Section, WHO, will also be with us for this same session. It is quite a number of years since Miss Creelman has been with us for a CNA meeting. We shall welcome her not only as an international nursing figure but also as a fellow Canadian.

Conference on Rehabilitation

The Victorian Order of Nurses for Canada held a national Conference on Rehabilitation in Ottawa November 7-9, 1957. This first conference to be held in the Order's new headquarters, 5 Blackburn Avenue, Ottawa, was attended by 33 Victorian Order Nurses representing branches from Vancouver to Sydney, Nova Scotia.

The conference reviewed current methods of caring for patients with chronic illness and of assisting in their rehabilitation. In the past five years there has been a 45 per cent increase in V.O.N. visits to patients with heart and circulatory system diseases, diabetes, diseases of the central nervous system, anemias and cancer. Speakers included:

Dr. J. B. R. McKendry who spoke on diabetic care. Dr. S. Mirsky who discussed rehabilitation of patients with heart diseases. Dr. B. Primeau, medical consultant, Medical Rehabilitation and Disability Advisory Service, Department of National Health and Welfare. Mr. Ian Campbell, national coordinator, Civilian Rehabilitation Branch, Department of Labor. Dr. Alastair MacLeod, assistant director, Mental Hygiene Institute, Montreal, P.Q.

A symposium on community aspects of rehabilitation was held with the following panel of experts participating:

Dr. J. S. Crawford, director, Department of Physical Medicine, Toronto Western Hospital. Mrs. Betty Hutchinson, registered nurse of the same institution. Mr. Bruce McKenzie, Department of National Health and Welfare. Miss Dorothy Madgett, physiotherapist, Toronto.

Miss Madgett emphasized that it was not only the disabled person who must be relaxed but the nurse and the patient's family as well. She stated that

In a chronically ill person there is constant frustration and pain. His tension gradually builds causing pain to increase. Before any type of therapy can be practised we must teach patients to relax.

So effective was the demonstration on relaxation given by Miss Madgett that one newspaper reported 33 V.O.N. nurses fell asleep on their speaker.

The Committees Meet

November 21-23, 1957 — Committee on Nursing Service met in Halifax.

December 12-14, 1957 — Committee on Nursing Education met in Ottawa.

February 13-15, 1958 — Canadian Nurses' Association Executive Committee will meet in Ottawa.

Prior to February, it is expected that the Committees on Legislation and By-Laws, Public Relations and Program will likely meet. From then on your National Committee chairmen will be busy preparing reports on the accomplishments and recommendations arising from the work of these committees. Recommendations and resolu-

tions requiring approval of your voting delegates at the CNA 50th Anniversary Meeting will be outlined as well as those requiring a vote by the general membership.

These National Committee reports must be in National Office by April in order to be printed for distribution to the registrants at the General Meeting.

As this biennium draws to a close and we plan for the future of nursing in our increasingly complicated world, nurses together with representatives of all related health fields must carefully consider the health needs of our fellow Canadians. This careful consideration has begun with the Canadian Conference on Nursing held in November 1957. In order to make this truly effective, provincial and local groups will wish to pursue a similar plan at their own level. It is only through this association that nursing will follow a path into the future which will truly lead to a better way.

Le Nursing à travers le pays

Congrès de l'A.A.H.P.

L'Association Américaine d'Hygiène Publique a tenu son 85ième congrès, du 11 au 15 novembre 1957. Plus de 4,000 personnes s'intéressant à l'hygiène publique se sont inscrites pour assister aux différentes séances sur: les soins médicaux, les soins de la mère et de l'enfant, le nursing en hygiène publique, l'hygiène scolaire et dentaire, la nutrition et l'alimentation, l'éducation en hygiène publique et sur divers autres sujets.

Ceux qui sont au courant des activités de l'A.A.P.H. seront heureux d'apprendre que l'on a rendu hommage à la mémoire du regretté **Dr. Reginald M. Atwater**, qui fut pendant 22 ans secrétaire-général de cet organisme. La mort subite du Dr. Atwater survenue vers le milieu d'octobre causa beaucoup de regrets parmi les hygiénistes. Lors de la présentation des Prix Laskers, un prix spécial fut présenté à Madame Atwater, en reconnaissance des services inappréciables rendus par le docteur Atwater dans le domaine de l'hygiène publique. La citation se lisait comme suit:

> A titre de professeur, de commissaire local en hygiène publique, de consultant, d'auteur et à plusieurs autres titres, Reginald Atwater a consacré sa vive intelligence, sa persévérance et sa personnalité bienveillante à l'exécution des tâches toujours de plus en plus complexes et d'une grande importance. Rares doivent être les dirigeants dans le domaine de l'hygiène publique de notre pays qui n'ont pas bénéficié, dans leur carrière, de son inspiration et de ses conseils; son influence heureuse s'est aussi fait sentir dans les pays étrangers.

Le **Dr. F. B. Mattison** a été nommé directeur général de l'A.A.P.H.

Les infirmières apprendront avec plaisir qu'un déjeuner fut offert en l'honneur de Mlle **Pearl McIver**, à l'occasion de son départ du Ministère de la Santé, de l'Education et du Bien-Etre des Etats-Unis, où elle était directrice du service du nursing. Cinq des collègues de Mlle McIver commentèrent élogieusement le travail qu'elle a accompli, à l'échelon international aussi bien que local.

La Conférence Canadienne sur le Nursing

Dans une autre partie de cette revue, vous lirez un compte-rendu de la Conférence Canadienne sur le Nursing, tenue sous les auspices de l'Association des Infirmières Canadiennes au cours du mois de novembre 1957. Vous pouvez vous procurer le rapport de cette conférence en vous adressant à L'Association des Infirmières Canadiennes, 270 ouest avenue Laurier, Ottawa, Ont. Ecrivez dès maintenant pour demander votre copie du rapport de ces intéressants débats à 75 cents.

Nous ne sommes peut-être pas indispensables!

En lisant la revue *World Mental Health Journal*, un article intitulé: Un Hôpital sans Infirmières (vol. 9, No. 3, pp. 119-122) a attiré mon attention. Voilà! A Tuzla, une ville de 40,000 habitants (Yougoslavie) une solution a été apportée au problème de la pénurie du personnel infirmier au département de pédiatrie d'un hôpital de 1,000 lits. Les mères ont été admises pour prendre soin de leurs enfants. Les 2 ou 3 infirmières de ce

service donnent les traitements compliqués, administrent les médicaments et enseignent aux mères. "Les seules personnes qui s'occupent du soin des enfants malades sont les mères." Le nombre total d'infirmières employées dans ce service de 130 lits est de 6: 3 le matin, 2 l'après-midi et 1 le soir.

Dans cet article l'on énumère les avantages d'un tel programme que nous résumons ici en quelques lignes:

Ce programme apporte une solution au manque de personnel.

Procure aux mères une expérience éducative qu'elles pourront avantageusement mettre en pratique, au foyer.

Hâte le départ de l'enfant, de l'hôpital.

Par-dessus tout, cette méthode semble satisfaire les besoins émotifs de l'enfant, facteur qui a une influence directe sur son retour à la santé.

L'article se termine par ces mots: "L'effet de l'amour maternel sur les maladies organiques n'a pas encore été étudié à fond."

Le programme se dessine

A la liste de nos conférencières invitées au Congrès marquant le 50ième anniversaire de l'A.I.C., vient s'ajouter le nom de Mlle **Agnes Ohlson**, présidente du Conseil International des Infirmières. Elle participera à une séance sur le nursing à l'échelon international. Nous sommes très heureuses de lui souhaiter la bienvenue.

Nous espérons beaucoup avoir parmi nous Mlle **Lyle Creelman**, infirmière en chef de la Division du Nursing de l'Organisation Mondiale de la Santé. Il y a déjà quelques années que nous n'avons pas eu le plaisir de la présence de Mlle Creelman à un congrès biennal de l'A.I.C. Nous l'accueillerons non seulement à titre de personnage international du nursing mais aussi comme infirmière canadienne.

Conférence sur la Réadaptation

Le Victorian Order of Nurses du Canada a tenu une conférence nationale sur la réadaptation, du 7 au 9 novembre dernier, à Ottawa. C'est la première conférence tenue dans les nouveaux quartiers-généraux de l'Ordre, 5 Avenue Blackburn, Ottawa, Ont. Trente-trois infirmières, représentant les différentes sections du V.O.N., de Vancouver à Sydney, N.-E., assistèrent à cette conférence.

Durant la conférence, l'on revisa les méthodes courantes du soin des malades chroniques et de leur réadaptation. Durant les cinq dernières années, 45% des visites des infirmières du V.O.N. furent faites à des personnes souffrant de maladies du coeur, de la circulation, du système nerveux central, du sang (anémie) de cancer et de diabète.

Parmi les conférenciers notons: Dr. J. B. R. McKendry, qui parla sur le soin des diabétiques; Dr. S. Mirsky, qui traita le sujet de la réadaptation des personnes atteintes d'affections cardiaques; Dr. B. Primeau, consultant médical du service de réadaptation des infirmes, Ministère de la Santé Nationale et du Bien-Etre social; Dr. I. Campbell, coordinateur national, Service de réadaptation des civils, Ministère du Travail; Dr. Alastair MacLeod, directeur adjoint de l'Institut d'Hygiène mentale, Montréal.

Un symposium sur les aspects sociaux de la réadaptation fut dirigé par: Dr. J. S. Crawford, directeur de la médecine physique du Toronto Western Hospital; Mme Betty Hutchison, infirmière du même hôpital; M. Bruce McKenzie, Ministère de la Santé Nationale et du Bien-Etre social; Mlle Dorothy Madgett, physiothérapiste, Toronto.

Mlle Madgett insista sur le fait que non seulement la personne malade devrait être dans un état de détente mais qu'il devrait en être ainsi de l'infirmière et de la famille. Les malades chroniques, continua-t-elle, se sentent constamment frustrés et souffrent. Cette tension, en s'augmentant cause aussi une augmentation de la douleur c'est pourquoi, avant l'application de tout traitement, l'on devrait enseigner au malade à se détendre.

La démonstration de Mlle Madgett sur la détente fut un succès d'après un journal qui rapporta que 33 infirmières tombèrent endormies en écoutant la conférence.

Réunions de Comités

Du 21 au 23 novembre 1957 — Le Comité du Service d'Infirmières se réunit à Halifax.

Du 12 au 14 décembre 1957 — Le Comité de l'Education en Nursing, à Ottawa.

Du 13 au 15 février 1958 — Réunion du Comité Exécutif de l'Association des Infirmières Canadiennes.

Avant la réunion de février, l'on espère que le Comité de Législation, des Relations Extérieures et du Programme se réuniront également. Les convocatrices de ces comités vont être, dès maintenant, très occupées à la préparation de rapports sur le travail accompli par ces comités et sur les recommandations qui auront été apportées. Les recom-

mandations et les résolutions devant être approuvées par les déléguées au Congrès de l'A.I.C., seront soulignées comme étant celles qui devront être approuvées par l'Assemblée générale.

Tous les rapports des comités devront être envoyés au Secrétariat national d'ici le mois d'avril afin d'être imprimés puis distribués aux congressistes.

A l'approche de ce Congrès biennal, nous faisons des projets pour l'avenir des infirmières, dans notre monde de plus en plus complexe. Les infirmières et les personnes s'intéressant à la santé devront considérer quels sont les besoins des Canadiens en matière de santé.

Cette considération fut déjà l'objet de la Conférence sur le Nursing mais pour assurer l'efficacité de ces recherches, elles devront être poursuivies par des groupes provinciaux et des groupes locaux. Ce n'est que grâce à une telle collaboration que les infirmières trouveront un meilleur chemin vers l'avenir.

Sélection

La cure de sommeil

Ce traitement psychiatrique peut se réaliser à l'hôpital général. Voici "le rôle de l'infirmière dans la réalisation d'une cure de sommeil," tel que présenté par Mlle Guivarch de l'Ecole des Cadres de la Croix-Rouge française.

Préparation:

— *du malade:* Pour réaliser une cure de sommeil, il faut d'abord l'accord du malade, pour qu'il accepte et soit dans un état de détente. Pour cela il faudra le prévenir de la durée du traitement, et lui dire que pendant ce temps il sera isolé de sa famille afin qu'il le sache, qu'il les prévienne et règle ses affaires personnelles. On le prévient aussi que si quelque chose de grave survenait il serait averti.

Ce n'est qu'alors que la cure de sommeil pourra être envisagée.

— *des matériaux:* On prévoiera une chambre seule, insonorisée si possible, tout au moins le plus calme possible. Elle sera aérée, à une température suffisante, et les fenêtres ne pourront pas être ouvertes par le malade. Un matelas serait préférable à un lit pour éviter les chutes, mais les malades ne comprendraient pas cette mesure.

Une fois la cure commencée, l'isolement sera complet, pas de lettres, ni visites, ni lectures.

Mise en route:

Après examens de la tension artérielle, du pouls et de la température, la cure commence. Elle se fait par ingestion ou injections de Largactil ou d'Enoctal, Immenoctal, Phénergan, l'un d'eux ou plusieurs associés, auxquels on peut ajouter du Laudanum et pour faciliter la déconnexion des suppositoires d'Isocurine.

Les doses sont réparties dans la journée en trois prises. On commence par des doses modérées car au bout de quelques jours il faudra les augmenter.

Les médicaments sont pris à heures fixes et la vie du malade est réglée en conséquence.

Le matin on réveillera le malade à heures fixes, puis il fera sa toilette prendra ses médicaments et déjeunera. De même à 12 hrs. et dans la soirée. Il pourra alors s'endormir après son déjeuner. Le sommeil est calme, et peu profond. Le malade peut facilement en être tiré, aussi faudra-t-il éviter le bruit ou tout ce qui pourrait le préoccuper.

La surveillance s'exerce toute la journée; les heures de sommeil seront contrôlées et une courbe en sera établie. Il faudra les surveiller jour et nuit. Il faudra prévenir les malades qu'ils ne *doivent pas se lever,* car ils s'exposeraient ainsi à des accidents tels que *syncopes ou collapsus.*

On les préviendra aussi qu'il faut *boire abondamment* pour permettre l'élimination des produits et éviter des accidents rénaux. L'infirmière devra surveiller la température matin et soir, le pouls et la tension artérielle, avant chaque prise de médicaments; des courbes en seront dressées. On notera aussi, en plus des heures de sommeil, l'état psychique des malades, s'ils sont toujours bien orientés, s'ils s'ennuient, deviennent

tristes ou confus. On surveillera les points d'injections, l'élimination des selles, et il aura à sa portée tout ce dont il peut avoir besoin, pour éviter qu'il ne se lève, ainsi qu'une sonnette.

Evolution:

La cure se poursuit souvent 15 à 20 jours. Un cap important à passer, est celui du *5e ou 6e jour,* les médicaments commencent à moins bien agir, et souvent les malades désirent alors arrêter le traitement. Il faut augmenter les doses pour passer ce cap, ou en avoir raison par psychothérapie.

A la fin du traitement, les médicaments seront baissés progressivement. Ce sera surtout le moment de la psychothérapie, et le malade devra reprendre bien vite une activité, pour éviter qu'il ne se complaise alors dans le repos, en délaissant son travail ou sa famille.

Durant tout ce temps jusqu'à la fin du traitement, l'infirmière aura un rôle de surveillance et de psychothérapie.

—*Revue de L'Infirmière et de L'Assistante Sociale,* Nov. 1955

Bronchopneumonia

FRANCES SLAGER

JOANNE GREGORY, aged 14 months, was admitted to the hospital with all the signs and symptoms of bronchopneumonia. She was the child of healthy, intelligent parents of an average income group.

Joanne's birth had been a breech delivery and her general physical condition following birth had been good. However, very early in life she had developed some degree of acute laryngotracheobronchitis that had subsequently cleared.

MEDICAL HISTORY

When she came into hospital the baby had labored breathing with indrawing of the chest wall on inspiration; a barking cough with a rattling sound accompanying respirations; cyanosis; restlessness and a fever of 100.3. She had a poor appetite and difficulty in swallowing. During the time she was in the hospital she vomited on several occasions. The emesis contained large amounts of mucus and curdled milk. Joanne appeared ill — her facial expression was listless and her eyes were dull and partially closed most of the time.

On x-ray dense areas were seen around the hilum and bronchus of both lungs. Normally these should be clear. The urinalysis was normal. Hemoglobin estimation was 10.8 gms. per 100 cc. of blood. Average hemoglobin content is 15 gm. per 100 cc. of blood.

TREATMENT

An oxygen tent was necessary to relieve the cyanosis and dyspnea due to inadequate oxygenation of blood. Inflammatory exudate filled the alveoli and constricted the air passages, thereby, reducing the surface area available for gaseous exchange. Continuous steam inhalations aided in moistening the mucous secretions so they could be coughed up and expectorated. The moisture helped to soothe the irritation in Joanne's inflamed respiratory passage.

MEDICATIONS

Sodium Luminal for restlessness due to cough, dyspnea and general malaise

Achromycin to destroy the invading organisms and prevent secondary infections

Corophylline suppositories for dyspnea due to constricted bronchioles

Acetylsalicylic acid for pyrexia, which is the body's defense mechanism against invading organisms. This drug acts by dilating cutaneous blood vessels causing a more rapid loss of heat.

Glucose 5% in saline (150 cc. at a time) per hypodermoclysis to prevent dehydration when the child was unable

Miss Slager, who is a graduate of St. Elizabeth Hospital, Humboldt, Sask., wrote this study while she was an intermediate student.

to take sufficient fluids orally

Colonic lavage, cold packs and alcohol sponges to assist in lowering temperature

Calcium gluconate for neuromuscular irritability particularly during fever when twitchings were frequently noted as well as one convulsion.

Nursing Care

This consisted largely in close observation of the child and watching for changes in her condition since she was both too ill and too young to be aware of them herself. It was necessary to restrain the child part of the time to prevent her from getting burned with steam. General nursing care was somewhat more difficult while maintaining continuous oxygen therapy per tent. The head-low position facilitated drainage of secretions and prevented aspiration of vomitus. Frequent suctioning was found essential to remove mucus. The administration of medications orally was impossible for a time due to frequent vomiting. Intramuscular injections of achromycin were necessary.

Two major problems in nursing care were encountered. One was to maintain an adequate fluid intake and prevent dehydration. This was partially overcome by hypodermoclysis. In addition small amounts of dilute milk were given orally when this could be tolerated. The other difficulty was to keep the child's temperature below 99°, since it persistently rose despite cold applications and aspirin. Colonic lavage was useful in reducing temperature as was the air-conditioning unit of the oxygen tent, which was maintained at 64°.

When she began to recover, it was difficult to keep Joanne satisfied while she was enclosed in the oxygen tent. Her own toys from home helped her to pass the time more contentedly. Occasionally we took her out and sat holding her, as she looked for affection.

In hospital where antibiotics and other symptomatic treatment are available, prognosis is good for the patient with bronchopneumonia. Without these, death may occur — depending on the severity of the condition and individual resistance. Joanne's prognosis was good because she had been in good health previously.

Normal Development

At 14 months, a normal child:

1. Can walk, sit, run and climb.
2. Attempts to dress himself and can usually remove most of his clothing if it is simple.
3. Is able to handle a spoon although rather shakily, and understands that a high chair is the place to sit to eat.
4. Will sleep about 12 hours at night and from one to three hours in the afternoon, depending upon the individual.
5. Enjoys playing with pull toys, little wagons, cars, blocks, colored pictures and animals. During her convalescence, Joanne sat looking at a magazine and spoke the first words that her nurse had heard her say. She indicated "mommy," "daddy," "baby" and "milk."
6. Has approximately 10 to 12 teeth through — the upper central and lateral incisors, the lower central and lateral incisors and four anterior molars.
7. Has an average weight of 20 — 24 pounds.
8. Has fairly well established toilet habits provided something more important does not delay attention to the task.
9. Takes soft and semi-solid foods well and has a variety of likes, as well as one or two inevitably acquired dislikes. Children this age rarely need encouragement to drink milk. They take it eagerly.

Joanne's Development

1. After she had recovered from the acute stage of her illness, Joanne was able to walk around and would sit rocking in her chair quite contentedly. She was not too lively at this time. Her illness had made her rather weak, but just previous to discharge she was as enthusiastically active as we would permit her to be. She liked to "help carry" the waste paper pail out to be emptied but tired quickly at play.
2. Joanne was always happy to be getting dressed and in this was rather different from many children who are just as happy to be nudists. She would hold out her arms or stand with one foot up to help.

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supplied: PARACORT and PARACORTOL are available as 5 mg. and 2.5 mg. scored tablets; bottles of 30 and 100.

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3. Joanne never fed herself in the hospital. She ate well after she began to convalesce. During the time when she was quite ill, she reverted to drinking from the bottle and made little attempt to hold it for herself.

4. She slept nearly all the time at first, waking only when aroused. Later on she was quite alert during the morning, although she slept long in the afternoon.

5. Joanne was quite alert and intelligent. She was interested in a variety of toys, especially magazines and soft animals. She had a lively interest in the chart desk, too.

6. She had 10 teeth through and did not seem to be troubled with sore gums.

7. Her weight was 22 pounds, not quite triple her birth weight of seven pounds, eight ounces.

8. Her toilet and eating habits were certainly well established for such a young child. While in the oxygen tent she was too sick to have control of elimination, but later, with encouragement, she asked to go to the bathroom whenever necessary.

9. She had only one food dislike — she hated spinach in any form. Apart from that she ate well, including bread crusts, with encouragement.

Teaching the Child

Joanne had mastered most of the skills common to a child of her age. She was quick to learn and would be ready to master dressing herself alone soon, as well as feeding herself. She had a good memory, so that showing her pictures and repeating names enlarged her vocabulary very readily.

Teaching the Parents

The parents seemed to manage quite well in caring for their children. Apart from stressing immunization, particularly for Joanne who is somewhat prone to respiratory infections, and the importance of early recognition of symptoms of illness, plus regular visits to the doctor, not many points of instruction were required.

Using the Index

Each year as the last issue is completed, the file of index cards that has been building up for the previous twelve months is closed, checked, typed and readied for the printers. With any sort of luck, the Index becomes available early in February. A half-page application form for one or half a dozen copies was published last month and appears again in this issue. The Index has been printed as a separate little volume for the past 14 years, rather than being bound into the December issue.

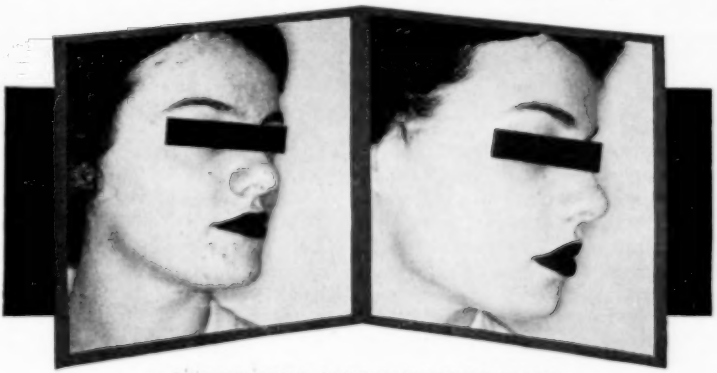
Started originally in its separate form as an economy measure when paper was in short supply during the war, two or three thousand copies of the Index are available for subscribers each year. That seems an extraordinarily small number of copies to order when one considers that there are about eighteen times that many names on our mailing list. Yet there still are hundreds of copies of the 1956 Index available. Moreover, about a third of the 500 copies of the Cumulative Index that was produced in 1955, covering the preceding five years, are still on hand. Why do so few readers of *The Canadian Nurse* use the Index? Inquiry reveals that most nurses are not aware of its usefulness to them.

Just what is an index? There are many varieties, many arrangements, many forms in which indexed material may be made available. Our index is an alphabetical listing of all the articles, authors, books, news items, subject matter, etc., included in each of the twelve issues of a calendar year. A nurse may recall the title of an article but forget the author; she may remember the author's name but forget the title; she may forget both the author's name and the article's title and recollect only that there was an article dealing with the nursing care of a patient with a kidney complication following abdominal surgery in one issue. In any of those instances, the index will reveal the correct page number instantly. Even the inconvenience of hunting through two or three issues for page 448, for instance, is eliminated because all page numbers are listed for each month's issue on the first page.

The first use of the Index, then, is to

(Continued on page 62)

see how Fostex® helps in treatment of acne



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Fostex effectiveness is provided by Sebulytic® (sodium lauryl sulfoacetate, sodium alkyl aryl polyether sulfonate, sodium dioctyl sulfosuccinate), a new combination of surface active cleansing and wetting agents with remarkable antiseborrheic, keratolytic and antibacterial action, enhanced by sulfur 2%, salicylic acid 2% and hexachlorophene 1%.

Fostex Cream for therapeutic washing of skin in severe, oily acne. Also as a therapeutic shampoo in dandruff and oily scalp.

Fostex Cake for therapeutic washing of skin after acute phase of acne is controlled. Maintains skin dry and comedone free.

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Empyema

MAGDALEN SCHROETER

JACK DALSEG was admitted to hospital by wheelchair. He was rather weak and fatigued and had had a constant fever for some time. No cough was present, but he was short of breath and had a feeling of fullness in his right chest. Cardiac palpitation was quite marked.

SOCIAL HISTORY

Mr. Dalseg is of Norwegian descent. He is 25 years old, married and the father of a little girl. He owns a store jointly with his parents and has an apparently adequate income. Since his occupation is not hazardous to his health he intends to return to his job after his convalescence. All other members of his family are healthy.

PERSONALITY

Mr. Dalseg is rather quiet in manner but he appears well adjusted and mature. His intelligence is average. At times he appears to be somewhat worried but generally suppresses this attitude successfully. Financial difficulties do not seem to be the cause of his worry. He has hospitalization and his brother-in-law is helping at the store whenever necessary.

MEDICAL HISTORY

Apart from the usual childhood diseases — mumps, measles and whooping cough — Mr. Dalseg has had little illness. A number of weeks ago he assisted in lifting a refrigerator onto a truck. Later he felt some pain in his right chest but afterwards was fairly comfortable for the rest of the day. On the following day he experienced severe pain in his right chest and after seeing his doctor was admitted to a hospital where he stayed for seven weeks. His diagnosis on admission was spontaneous pneumothorax. Eventually this developed into a hemopneumothorax and then became an empyema thoracis. Treatment given in that hospital consisted of intermittent aspiration of the affected pleural cavity and later closed drainage.

Aspiration was done in an effort to promote re-expansion of the collapsed lung and to remove accumulated fluid such as serous exudate, blood and pus. Closed drainage was finally established to serve the latter purpose. During his stay in hospital, Mr. Dalseg ran an intermittent fever. After seven weeks he went home for three days, then was admitted to our hospital.

His diagnosis was empyema thoracis — a collection of pus (abscess) in the pleural cavity anywhere between the parietal and visceral pleura. This may also occur in the interlobar spaces. During his illness the patient had lost approximately 30 pounds.

The physical examination performed by the interne on admission did not reveal any abnormalities except pinkish discharge from the incision in the right posterior thorax.

LABORATORY FINDINGS

Mr. Dalseg's hemoglobin was 66 per cent (normal: 90-100 per cent). His white blood cell count was 12,600 (normal: 5000-9000). This indicated slight anemia and the presence of an infectious process somewhere in the body. Blood transfusions were given and the level of hemoglobin rose to 74 per cent.

The urine was found to be loaded with bacteria. There were calcium oxalate crystals also and a heavy deposit of urates. Other values were normal.

A culture of aspirated material from the pleural cavity showed Staphylococcus *aureus*. The organisms were sensitive to Furadantin, Ilotycin, Erythromycin, and Bacitracin.

X-rays showed fluid in the right hemithorax posteriorly and anteriorly. The left lung proved to be clear. The roentgenologist reported a right posterior hydro- or pyopneumothorax. A bronchopleural fistula was thought to be present

---

Miss Schroeter did this study while she was a student at the Misericordia Hospital, Winnipeg.

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- phosphorus-free calcium helps prevent leg cramps due to phosphorus imbalance
- Vitamins K and B_6 give added protection . . . comprehensive formulation includes important minerals and trace elements

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Each capsule contains:

Vitamin A	4,000 I. U.	Vitamin K (Menadione)	0.5 mg.	Manganese (as MnO_2)	0.05 mg.
Vitamin D	400 I. U.	Folic Acid	1 mg.	Magnesium (as MgO)	0.15 mg.
Thiamine Mononitrate (B_1)	3 mg.	Iron (as Fumarate)	30 mg.	Molybdenum (as $Na_2MoO_4 \cdot 2H_2O$)	0.025 mg.
Pyridoxine (B_6)	1 mg.	Stomach Mucosa	5 mg.	Zinc (as ZnO)	0.085 mg.
Niacinamide	10 mg.	Fluorine (as CaF_2)	0.015 mg.	Calcium (as Carbonate)	230 mg.
Riboflavin (B_2)	2 mg.	Copper (as CuO)	0.15 mg.		
Vitamin B_{12}	2 mcgm.	Iodine (as KI)	0.01 mg.		
Ascorbic Acid (C)	50 mg.	Potassium (as K_2SO_4)	0.835 mg.		

Dosage: one or more capsules daily, or as directed by the physician
Supplied: attractive, re-usable bottles of 100 capsules.

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Lederle CANADA

because of a large collection of air. After several days of treatment a repeat of the chest film showed considerable reduction of pleural fluid. No appreciable air or fluid level was found.

Treatment

The three main aims of the treatment were:

1. to eradicate the infection;
2. to promote expansion of the lung;
3. to aid the patient in regaining his weight and strength.

Surgery: A thoracotomy was performed and a three-inch segment of left rib removed. The pus was evacuated, a large drain inserted and the opening maintained with wire sutures and a rubber glaze-seal applied to prevent leaking. After Mr. Dalseg's return from the operating room a closed drainage with facilities to irrigate the abscess cavity was established by the doctor. A suction machine was connected to the outflow tube to speed the evacuation of the fluid.

Diet: A high protein and high caloric diet was ordered to replace the protein lost through pus formation and to aid the patient in regaining his weight. Supplementary feedings were given in the form of "Ledinac" and "Sustogen." Supplavite tablets were given as a vitamin additive. Buttermilk was ordered for the relief of abdominal distention.

Medications:

Aspirin gr. V one dose on admission, as an analgesic.

Morphine gr. 1/6 postoperatively, as a narcotic and analgesic.

Ilotycin 250 mgm. — an antibiotic to combat infection. Given orally first and later intramuscularly because the patient complained of tympanites.

Chloralol tab. 2 later replaced by nembutal gr. III were given as necessary for insomnia.

Blood transfusions were given to raise the hemoglobin.

Iron gluconate gr. V helped to raise the hemoglobin.

B12, 100 mgm., a vitamin preparation, was given as a single dose. It also plays a role in blood formation.

Dakin's solution, an antiseptic which rapidly destroys bacteria and devitalized tissue, was used as an irrigating solution.

Nursing Care

Preoperatively: Reassurance is extremely necessary. The operation was explained to the patient so that he understood what to expect when he came back from the operating room. The operative area was shaved, cleansed, and in this case — as ordered — was washed with Phisohex.

The patient voided before going to the operating room. His dentures were removed. Fasting after midnight is necessary if the patient is to have general anesthesia. Mr. Dalseg was given local anesthesia.

Postoperatively: When Mr. Dalseg came back from the operating room the doctor connected the drainage tubes to the irrigation bottle and to the suction.

The duties of the nurse giving nursing care to him included the following:

A daily sponge bath
Proper mouth care
Maintain Fowler's position to promote drainage
Prevent kinking or pulling of drainage tubes
Change position from side to side at frequent intervals
Support and make comfortable with pillows
Prevent decubiti by giving proper back care
Accurate output records of urine and drainage and intake records of fluid
Observation of the quality of urine
Observation of bowel function
Watch for respiratory distress
Force fluids and encourage eating
Careful observation of the suction as to maintenance of the desired pressure, prevention of overflow of the bottle, any leaking around the tubing
Help the doctor with the dressings
Irrigation of the abscess as ordered and observe character of the return flow
Prompt administration of all medications as ordered and observation for untoward effects
Watch for any reaction after blood transfusions
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given, all medications and the diet.

The environment should be neat at all times, quiet and well-ventilated. Drafts should be avoided. Provision should be made for light activity and entertainment such as reading, radio, and television. Meals should be served attractively to stimulate the patient's appetite. The patient should be protected from emotional upsets. The number of visitors should not exceed two at a time to prevent the patient from becoming overtired or exhausted.

When caring for Mr. Dalseg, a cheerful and reassuring manner was helpful to him. He had to be prepared for a prolonged stay in the hospital. His nurses tried to fulfill any extra wishes for him within a certain limit while avoiding pampering and at the same time tactfully teaching him the value of independence.

Prognosis

Considering the improvement demonstrated by the repetition of his chest x-ray, one could say that the outlook is very promising. Another culture was made from material aspirated from the pleura. After 48 hours of incubation no bacterial growth could be demonstrated which seems to indicate that the infectious process had stopped. These are very encouraging signs, and if Mr. Dalseg's improvement continues in this direction, his complete recovery should take place in the near future.

The only obstacle that has to be overcome is the complete evacuation of the pleural space which consequently should result in the desired expansion of the lung. A complication which should be taken into consideration is the possibility that the thickened pleura surrounding the remaining cavity would prevent the expansion of the lung. This might necessitate a decortication operation — a procedure designed to achieve expansion of the lung by peeling off the indurated and thickened part of the pleura.

Health Teaching

Although from a medical point of view the patient seems to be making excellent progress, he very likely will require a relatively long period of convalescence in order to regain the strength necessary to carry out his daily routine of work.

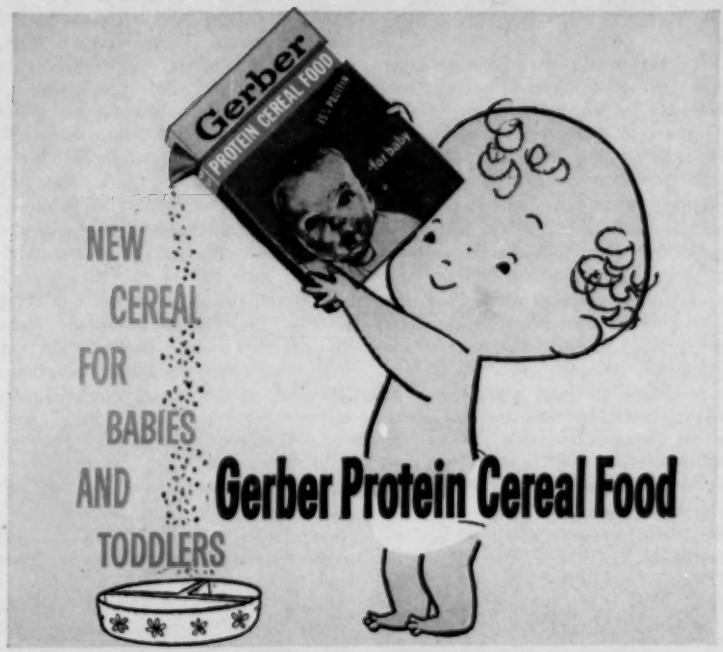
The two main items in his health teaching were the necessity for maintenance of his high caloric diet and the importance of rest, physical even more than mental. Before Mr. Dalseg left the hospital the dietitian had an interview with him and explained his diet. She gave him an outline of the nutrients or foods which should be included. He was cautioned to start manual work slowly. Above all, he was not to attempt any lifting for a long time in order to prevent a repetition of his condition.

Any contact with colds or other infectious diseases should be carefully avoided. To promote the flexibility of the affected lung as well as to prevent adhesions between parietal and visceral pleura the doctor ordered breathing exercises such as blowing up a rubber ball. To gain the patient's cooperation the nurse explained the reason for this procedure and convinced the patient of the necessity of carrying out the doctor's order. Frequent follow-up visits to his doctor after discharge from the hospital were suggested. The nurse stressed the importance of this to Mr. Dalseg.

There is no end to the quiet but immensely exciting business of really getting acquainted with words. A word may appear dull and flat or worn and tired. But stop it and question it and you may find that behind the conventional exterior there is a fascinating, not to say romantic, history and "personality." Take some commonly used medical words for example . . . *Delirium* in its literal sense means an improperly ploughed field. Roman farmers who took pride in their fields were especially concerned that the *lira* or furrows in ploughing were straight. A careless farmer whose furrows were wavy and irregular was said to be *delirare*. Thus a person whose mental faculties were disturbed and departed from normal was termed *delirius* and so came our word *delirium*.
—Dr. E. P. Scarlett in *Historical Bulletin*

* * *

The wine-colored amethyst received its name, which means "not drunken," because it was supposed to keep the wearer of it sober.
— Sir James Frazer



COMPOSITE ANALYSIS

	Percent
Protein—N X 6.25	35.00
Fat—Ether Extract	1.65
Available Carbohydrate—By Difference	48.74
Crude Fiber	1.48
Ash—Minerals	7.26
Ash Includes	
Calcium	0.859
Phosphorus	0.930
Iron	0.050
Moisture	5.87
Calories Per Ounce	99

One ounce approximately 12 tablespoons.

VITAMINS

Expressed as milligrams per 100 grams.	
Thiamine	2.8
Riboflavin	2.1
Niacin	14.0

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Exceptional nutritive value. Gerber Protein Cereal Food is a new baby cereal, designed to increase the protein intake of babies and young children. The high total protein content (35%) combines proteins from oats, wheat, soy beans and yeast. In combination, these vegetable proteins are utilized most efficiently—and offer the mother an economical way to provide protein in easy-to-digest form. For further nutritive value, Gerber Protein Cereal is fortified with iron, calcium and B-vitamins.

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Book Reviews

The W.G.H. School of Nursing by Ethel Johns. 85 pages. The Alumnae Association, Winnipeg General Hospital. Price $2.00.

Warm congratulations are the due of the Alumnae Association of the Winnipeg General Hospital for the lively history of the first 85 years of their hospital, written by one who was not only an active participant but who also was personally acquainted with so many of the early leaders. The brief biographical sketches that form a part of the story, give a warmth that is so often lacking in a history of nursing.

Miss Johns has given us much more than the history of one hospital. It is a graphic description of the struggles that were nationwide to provide adequate education for students, to reduce the long hours they were required to work, to eliminate the schools started in "five-bed hospitals"; to provide greater security for patients and nurses alike through improved educational requirements and later, through legislation, by registration. The progress in reaching these and similar goals is related directly to the administrative epochs of the several directors of nursing. There was no easy road to any of these developments. The truly amazing thing is the fortitude and persistence shown by so many nurses in eventually reaching them.

There is plenty of humor, too, for the "lowly probationer" who hadn't even a classmate to share her woes when training was started, has a prodigious memory for the little things that clothe the personalities with vitality.

There are all too few intimate glimpses of the professional growing pains of Canadian schools of nursing. Without delay each of the present schools should add this slim volume to their students' reference library. Graduates of other hospitals will share in the joy of achievement this book so adequately portrays.

When Your Child is Ill by Samuel Karelitz, M.D. 485 pages. Simon and Shuster, Inc., Rockefeller Center, 630 Fifth Ave., New York 20. Price $4.95.

Reviewed by Miss Shirley J. Paine, Assistant Director of Nursing Education, Children's Hospital, Winnipeg.

Never before, perhaps, have so many people been so health-conscious and desirous of exact information about illness. This is evidenced by the numbers of articles in the press and popular magazines about a great variety of health problems. These serve, in part, to answer questions but, too often, they only stimulate curiosity without satisfying it.

The author of this volume has presented an up-to-date general picture of childhood illnesses in a manner that should satisfy the curious and intelligent parent. The book is recommended reading also for doctors and nurses who will find it an aid in answering many questions asked during the illness of a child.

A special feature of the book is the questions and answers that follow the discussion of each topic. These questions are derived from many commonly asked the pediatrician. They help to summarize, point up, or expand the information contained in the chapter.

All sections of the text except the first deal with disease conditions. Each of these conditions is discussed under subheadings such as contagion, symptoms, complications, prevention and treatment. This enables the reader to find the information he is seeking quickly. In the section on fever there is an excellent discussion of the uses and dangers of aspirin and the significance of an elevated temperature. The section on immunization is complete and convincing.

While perhaps not of serious concern, the book is written at a level that presupposes a high degree of education and comprehension. The parent who has had little education or has a language problem might find the discussions beyond him.

There is an extensive glossary that supplements the material in the book. It would explain many terms frequently used by nurses and doctors who forget that the words they use in their everyday conversation are often quite strange to even well-informed parents.

Dr. Karelitz says in part "the doctor . . . often wishes there was some way for parents to find the answers themselves to perfectly routine questions that would not necessitate calling him or having him see the child." This book will answer a great many questions of this nature and will provide excellent additional information.

Basic Nutrition by E. W. McHenry, M.A., Ph.D., F.R.S. (C). 380 pages. J. B. Lippincott Company, 4865 Western Avenue, Montreal 6. 1957. Price $5.00.

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Reviewed by Miss Jean Macdiarmid, Director of Dietetic Services, Dept. of Veteran's Affairs, Ottawa.

Dr. McHenry has presented nutritional information in a very readable, interesting style that should make studying a pleasure rather than a chore. Its use as a textbook presupposes a background of at least elementary courses in biochemistry and physiology.

Since nutrition, with all its implications, hinges on food consumption the subject is approached by describing the physiological factors that produce hunger and the factors that influence the choice of foods to satisfy the desire to eat.

Only by the use of nutritional knowledge can food be selected to meet all requirements for growth and maintenance of health. Much of the modern interest in the value of different foods stems from a desire to cure or prevent disease. It is not enough for us to know that certain food constituents are essential for health. We must know how much of each constituent is contained in different foods and what quantity of these foods should be eaten. Methods of nutritional investigation and means of determining energy production of food elements are delineated.

Basic information concerning food constituents (carbohydrates, fats, proteins, etc.) is the backbone of any nutritional text. The unessential has been eliminated which has resulted in clarity of presentation. Current thinking concerning the relationship of cholesterol to atherosclerosis and coronary disease has been presented, as has the relationship of carbohydrates and fluorine to dental caries.

Dietary standards of the United States and F.A.O. as well as Canadian dietary standards have been dealt with comprehensively. At the same time it has been pointed out that a dietary standard has no practical value until its scientific terms are translated into recommendations regarding selection of foods in kind and in quality to meet estimated needs.

Modifications of normal nutrition are essential to meet the demands of pregnancy, lactation and for the treatment of a variety of diseases. These modifications are usually referred to as "Special Diets" and the chapter dealing with this subject is so captioned. Information is included on the most up-to-date conception of obesity and weight control. Use of the Basic Seven or Canada's Food Rules is recommended as a sound way to form food habits that will prevent obesity. It is stressed that "fad" reducing diets, either promoted by manufacturers of special products or popularized in magazine articles can too often be nutritionally inadequate.

The text ends with a chapter dealing with the causes and prevention of malnutrition. Malnutrition exists in prosperous as well as less prosperous countries because of ignorance and indifference. An expanded program of education can help to overcome this hazard.

Using The Index

(Continued from page 52)

find specific articles when they are wanted.

Another use to which the Index should be put, especially by instructors in our schools of nursing, is in the preparation of reference reading lists. Not long ago, when talking to a senior class of student nurses about *The Canadian Nurse*, this value of the Index was mentioned. It so happened that the class had been given a reference list on geriatric nursing by their instructor only a day or two before, which was promptly exhibited. Imagine our dismay and discomfiture to discover that in a listing of about 18 articles, there was *not a single mention* of the very fine series of articles on this topic that had been carried in *The Canadian Nurse* in 1956! While there is no dispute over the value of including references from American and British periodicals, genuine effort should be made to acquaint every student, early in her nursing career, with the things she can find in her *own* professional journal.

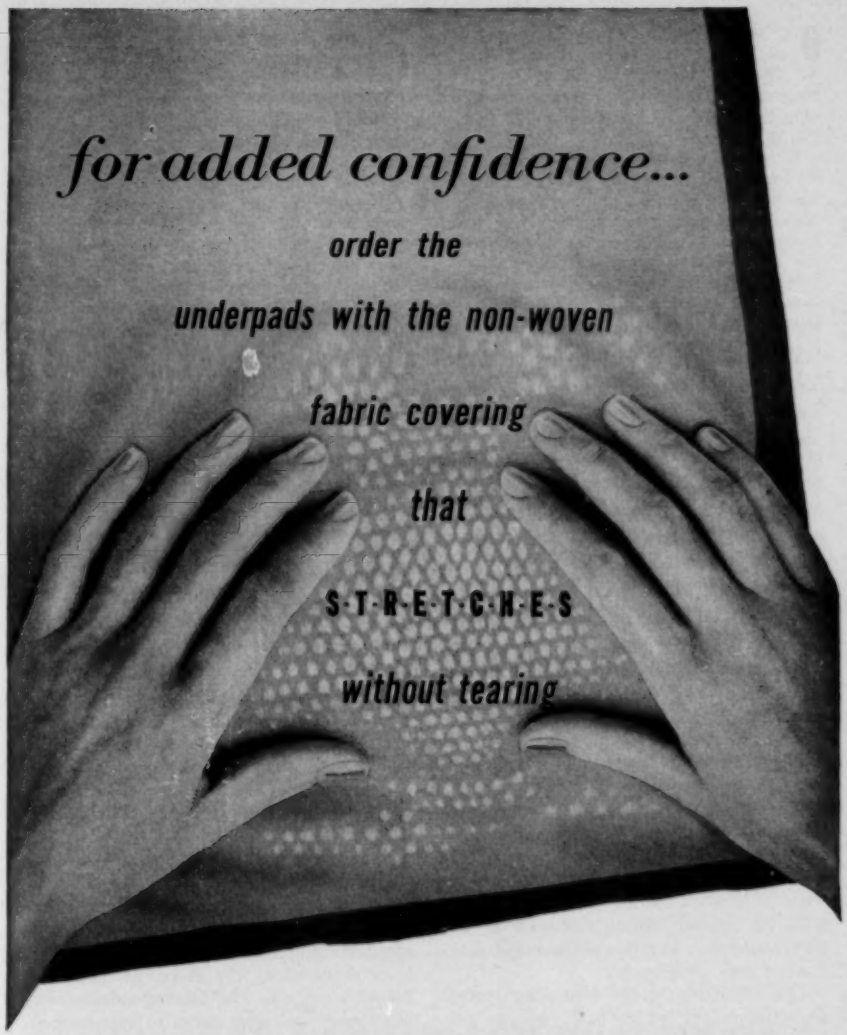
A logical result of using the Index more frequently for reference purposes would be an increased awareness of all that pertains to our profession whether it be clinical material or factual information concerning new developments. What do you know about the Pilot Project for the accreditation of schools of nursing, for instance? Almost every issue this year has had some reference, long or short, to the Project, to its new director, to the provincial association's financial support for it, etc. It is time-saving and far more accurate to trace the accumulation of material through the Index than to thumb through all of the 1152 pages that constitute Volume 53.

By sending in your order immediately it will be possible to order a larger quantity from our printer if the demand justifies it. Please send your order in quickly.

* * *

At a dinner party one should eat wisely but not too well, and talk well but not too wisely.

—W. Somerset Maugham



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Annual Meeting in New Brunswick

ONE HUNDRED AND FIFTEEN nurses registered for the 41st annual meeting held in St. Stephen, October 23-24, 1957. At the meeting the emphasis was on nursing service, with the theme "The Patient — the Hub of the Wheel."

In her presidential address, Miss Grace B. Stevens spoke of the spirit of optimism and enthusiasm in the nursing profession in New Brunswick as we attend to that which is our business — improving and enhancing the practice of nursing and examining the role of the nurse as a practitioner of patient care. She noted that, in this connection, the "Institute on Nursing Practice," the first of the recommendations of the Russell Report to be implemented, was then concluding its fourth and final week.

The 40 nurses registered for the institute in Saint John chartered a bus in order to attend the annual dinner at which approximately 200 were present. The guest speaker at the dinner was Dr. Muriel Uprichard, assistant professor at the University of Toronto. Her subject was "The Heart of the Matter," the love of the nurse for her patient. The three examples she gave of understanding and love in the nurse-patient relationship had special meaning in the development of her subject.

Dramatization of a staff conference in which 12 nurses took part, formed the program on the second day. The focal point of discussion at this conference was the presentation of a paper on better use of nursing time. Following the dramatization, the participants remained to take part in the lively discussion period that followed on both the subject matter discussed at this staff conference and the purpose and functions of staff conferences.

The highlights of the committee reports on activities during the past year are outlined as follows:

The amendments to the New Brunswick Nurses' Act passed by the Legislature in the spring of 1957; the proposed revisions of the by-laws, which included an increase of Council membership, adjustment of fees for reinstatement of membership and for registration by certification.

Recommendations to the chapter committees on public relations to assist them in defining the area of their responsibilities.

Revision of the recommended personnel policies of the N.B.A.R.N.

The activities of the Nursing School Adviser which have resulted in an improvement in the area of clinical teaching of student nurses; also the decision to continue with the oral and practical examination at the end of the first year.

The purchase of property for permanent headquarters of the N.B.A.R.N.

The increase of staff at provincial office in order to carry on the increased activities in nursing service and nursing education in the hospitals and schools of nursing in the province.

The first step taken in the issuance of certificates of approval to schools of nursing by a trial run on the evaluation of all schools using recommended standards previously set up by a committee.

The planning and carrying through of the first of a series of institutes on nursing practice, with the help of Miss Lillian Campion, Nursing Service Secretary, on loan from National Office, and the efforts to secure financial support to continue with a series of institutes in 1958.

A special report on the program covering the four weeks of the institute was given by Miss Bridgette McNamara, one of the registrants. The report included a recommendation to the meeting that a sample chart form prepared by the group be used as a research project. The recommendation was acted upon and steps taken to implement it.

MURIEL ARCHIBALD, REG.N.
Secretary-Registrar

Ontario

The following is a list of the staff changes in the Ontario Public Health Services:

Appointments — *Wilma T. Adair* (Women's College Hosp., Toronto, Univ. of Toronto) to North York Township Board of Health. Mrs. *Karl (Bradley) Bilzer* (St. Mary's Hosp., Montreal, McGill Univ.) to Ont. Co. Health Unit. *Norma (Skea) Bingham* (Oshawa Gen. Hosp., Univ. of Toronto) to Kingston B. H. *Julia Campion* (Health Visitor's Cert., Cert. of Queen's Institute of Dist. Nurs., Eng.) to Hamilton

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Resignations — *Lillian G. Barr* from Huron Co. H. U. *Margaret (McPhail) Harrison* from Wentworth Co. H. U. *Frances M. Lummiss* and *Esther V. Matheson* from Halton Co. H.U.

News Notes

ALBERTA

District 3

Banff

Cancer Drive collections under the direction of chapter members reached a record $1410.40 this year. The work of the Unitarian Service Committee was supported with a donation while the Baby Clinic served 35 families during the month of October and gave 65 Salk vaccine injections. A new slate of officers was elected and included the following: Mrs. P. Littemore, pres.; Mrs. J. Kelly, corr. sec.; Mrs. P. Duke, treas.

Calgary

This chapter is to convene the annual A.A.R.N. convention in Banff for 1958. In charge of the planning are Misses Moore, Wier and Quirk. A brief report of a recent provincial executive meeting given by Mrs. Duthie was highlighted by the announcement that the Alberta Association of Registered Nurses has bought a plot of land in Edmonton on which they plan to build an office. A Bursary Tea is to be held at Central United Church — final plans to be made at the February meeting. Mrs. Black has been chosen as representative to the Local Council of Women and Miss Tennant is the representative to the Council of Social Agencies.

Thirty-eight members attended a chapter supper meeting held in the nurses' residence of Holy Cross Hospital late in the fall. Letters of acknowledgement and thanks were received from Carol Osborne, Lucille McGlynn and Elizabeth Ann Goetz, scholarship winners, who plan to enter the schools of nursing of the local hospitals. The following slate of officers was elected for the coming chapter year: Mrs. M. Duthie, chairman; J. Cummins, vice-chairman; L. Kondo, rec. sec.; A. Stirling, corr. sec.; L. McComb, treas. Committee chairmen elected to office were Mrs. M. Lupypciw, C. Broad, Mrs. J. D. P. Nolan, D. Watrin, S. Thielen, M. Horne and I. Stewart.

District 7

Edmonton

Miss Lois Kremer was the guest speaker at the November meeting with "Nursing Aspects of Civil Defence" as her topic. A delegate attended the joint conference held at Red Deer and sponsored by the Nursing Education and Nursing Service Committees. An invitation to convene the Program Committee for the annual provincial meeting which is to be held in Banff, May 20-23 was accepted by the members. Funds were voted to pay the postage on books being sent to Miss F. Ferguson in Ceylon.

District 8

Taber

The treasury was richer by $35 following a successful sale of home baking early last fall. A bridge and whist party was held in November. Miss R. Lillie took charge of the Christmas hampers and a local resident who was a patient at the Baker Memorial Sanatorium received a gift parcel.

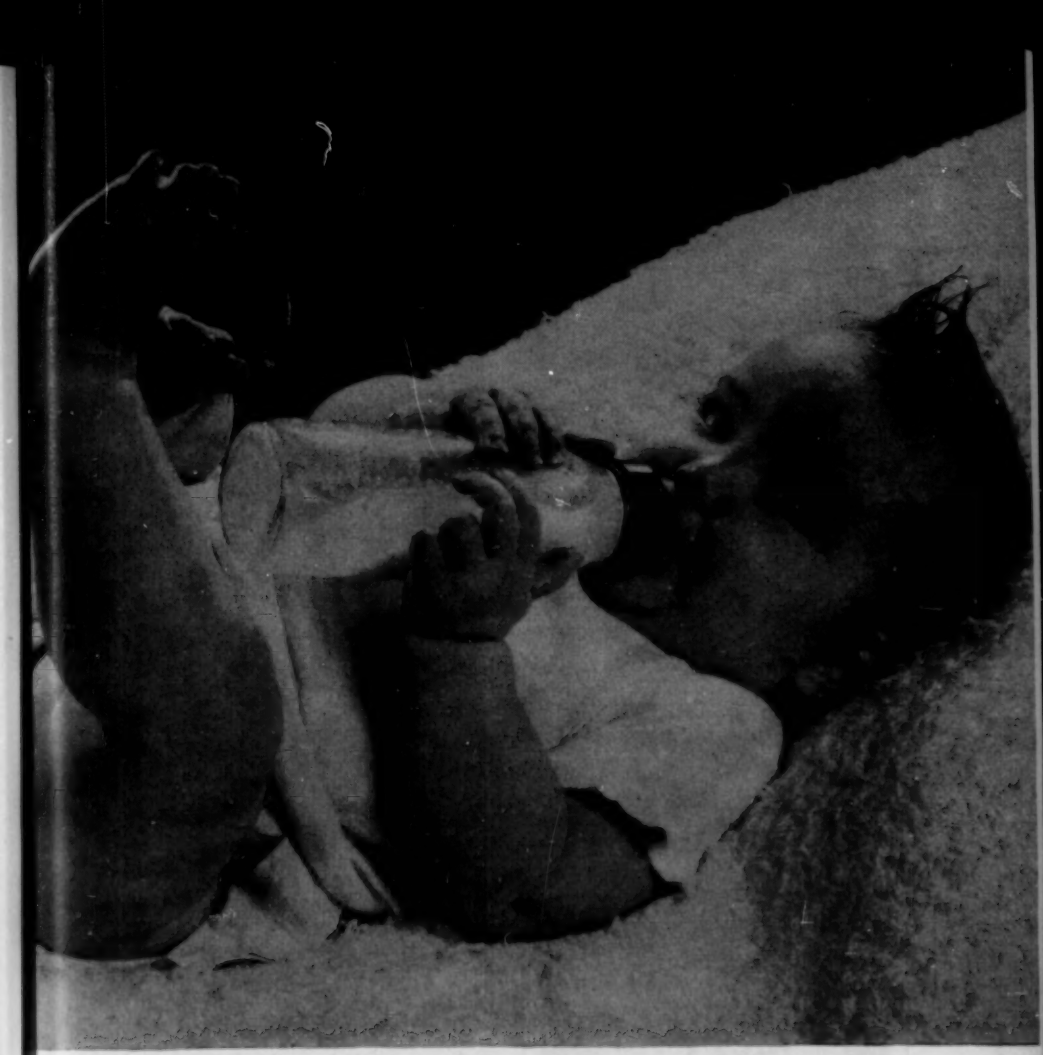
BRITISH COLUMBIA

Comox

The B.C. centennial is to be observed with special anniversary ceremonies. Sr. Eucharia is investigating the history of early nursing and hospitals in the area with a pageant of nursing as her objective. A Christmas party held at the home of Mrs. H. McQuinn was enjoyed by the members. The slate of officers elected for the current year includes: Mrs. W. R. Hind, pres.; Mrs. F. Dansereau, treas.; Mrs. E. Eirikson, corr. sec.

Penticton

Miss Ferne Trout, the new nurse supervisor of the Penticton Hospital, was welcomed to the membership of the chapter at a recent meeting. Mrs. E. F. Boulding presented a comprehensive report of the semi-annual district meeting held at Kamloops. It was announced that Mrs. D. W. Keir would be in charge of the local high school's Future Nurses' Club. Miss Vera White, the guest speaker, gave a very interesting talk on home nursing and civil defence.



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VANCOUVER

St. Paul's Hospital

The "Homecoming" held last fall, while successful, saw a smaller crowd in attendance due to the flu epidemic than had been hoped. The classes of '23 and '24 were honored guests. Letters and a telegram brought messages from several graduates unable to attend. The student nurses assisted with the program for the evening.

D. Ritchie, T. Sullivan, T. Hogan and H. Hull are attending the University of British Columbia where they are enrolled in the course in clinical supervision. Mrs. De Lasalle, Miss Gluk and H. Stewart are completing studies for their B.Sc. degrees.

MANITOBA

DISTRICT 2

The first district meeting of the fall and winter seasons took the form of a supper gathering attended by 70 nurses representing the towns of Souris, Ninette, Virden, Hamiota, Neepawa, Carberry and Brandon. Miss Christina Macleod, Winnipeg, was a special guest. Following the business session, E. Pattinson introduced the guest speaker, Laura Johnson. A graduate of the Winnipeg General Hospital, Miss Johnson holds the position of nurse consultant in the provincial Department of Health and Public Welfare. She was one of the Canadian nurses who attended the ICN congress in 1957 and her audience enjoyed her illustrated description of her visit abroad.

Brandon

"Nurses and the Law" was the subject chosen by Judge A. G. Buckingham of the Surrogate Court, western judicial district of Manitoba. He pointed out the unusual nature of nursing in respect to the law in that an error can not be corrected. Several cases of attempted court action against nurses and hospitals were given. During the informal discussion period that followed, the nurses asked various questions about legal matters as related to their work. Senior students of the General Hospital were special guests, and representatives from Erickson, Hamiota and Virden attended.

General Hospital

Reports from all committees denote a strong interest in the newly-organized alumnae association. A newsletter has been started and any information about graduates would be welcomed. Pictures of the reunion held in June, 1957 are still available for anyone who wishes to order them. The president of the association for the year is Mrs. H. S. Perdue and the corresponding secretary is A. Bennett.

NEW BRUNSWICK

Moncton

A regular chapter meeting was held at the Tuberculosis Hospital with Miss Margaret Hollenbeck presiding. The convener of the nursing education committee reported that seven nurses attended the clinical institute held in Saint John during October. The Cook Book committee reported that the second edition of the Cook Book is ready for sale. Mrs. N. Smith, delegate to the annual meeting of the N.B.A.R.N. held at St. Stephen in October gave a very interesting and detailed report of that meeting.

Saint John

The provincial association has taken a positive step towards implementation of the recommendations in the Russell Report on nursing education in the province. Under the direction of Miss Lillian Campion, nursing service secretary of the CNA, a month-long nursing institute was held at the General Hospital with selected nurses at the supervisory level from all the hospitals in attendance. The purpose of the institute was to enable the participants to carry back to their respective institutions knowledge and ideas that could be shared with their staffs.

A session on the techniques of interviewing and counselling was a highlight. A panel discussion on records and reports resulted in the formation of a study group to examine this aspect of hospital work and to bring in suggestions for simplifying and improving present charts. Considerable time was devoted to finding the ways by which nursing care may be improved and greater understanding of the individual patient may be developed. The physical, emotional, social and religious problems of a patient formed the basis of one discussion and rehabilitation and its tech-

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niques occupied the attention of the members on another occasion. In connection with the latter discussion, a visit was made to the Ridgewood Health and Occupational Centre where Miss Christine MacArthur, educational director for the Victorian Order of Nurses, demonstrated rehabilitative nursing techniques. "Continuity of Nursing Care" promoted lively discussion as members tried to arrive at satisfactory means of correlation between hospital nursing and the various community nursing services. Participants in this particular panel were: M. Hunter, director of P. H. nursing for the Dept. of Health; J. Anderson, director of nursing, Victoria Public Hospital; V. Hamilton, industrial nurse, International Paper Co.; A. Robichaud, from the faculty of Teachers' College, Fredericton; F. Saunders, district director of the V.O.N.

W. Hooser resigned as president of the Chapter and K. Donahue has taken over the office. M. Cavanaugh, secretary, and S. Nagle, program convener, also submitted resignations. Their places are being taken by H. Barry and A. Corkery. A wreath was placed at the Cenotaph on Remembrance Day on behalf of chapter members.

St. Joseph's Hospital

Bishop Leverman laid the cornerstone of the new 200-bed hospital late last October. Members of the hospital board also participated in the ceremony. The Kiwanis Club presented a gift of $500 to be used to furnish a children's playroom. It is expected that the new hospital will be completed and in service by February, 1958.

The annual Marigold Tea and Sale held under the auspices of the alumnae association was a delightfully arranged social occasion. The rooms were effectively and attractively decorated with chrysanthemums in autumn shades. An apron table, white elephant booth and candy table were features of the tea. I. Ryan, alumnae president, was the general convener assisted by Mrs. E. Donovan and Mrs. J. Kirk.

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NOVA SCOTIA

Glace Bay

The Cape Breton and Victoria Branch of the R.N.A.N.S. opened its fall activities with meetings at St. Joseph's Hospital and the General Hospital during September and October. Plans were discussed for the annual provincial meeting which will be held in Sydney in June. The association plans to publish a bulletin telling of chapter activities and other events in nursing beginning early this year.

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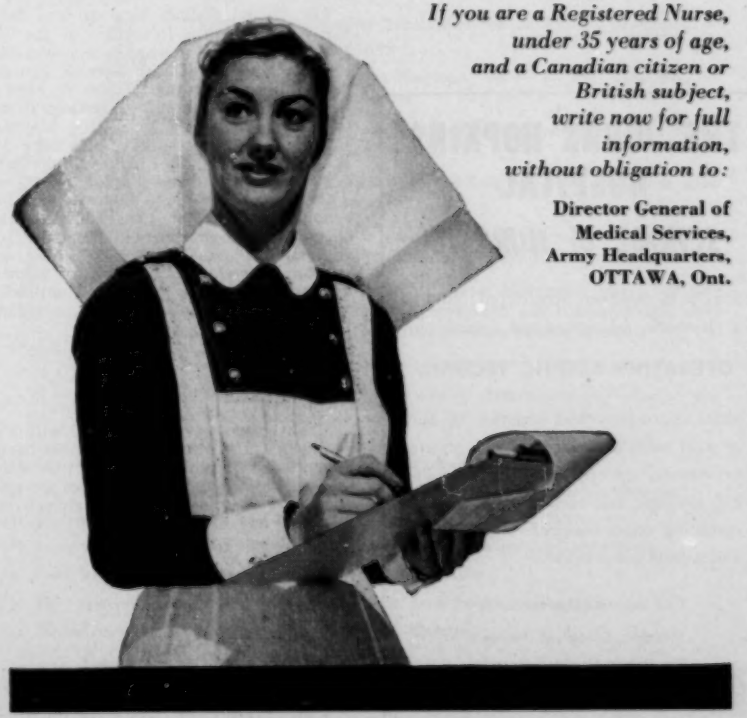

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WINDSOR

The Valley Branch held a meeting at the Payzant Memorial Hospital late in the fall. A Dutch auction provided entertainment and increased chapter funds.

The annual birthday dinner was celebrated by 90 members in mid-November. The ladies of Trinity United Church catered and beautiful red roses brightened the tables through the generosity of Mr. F. Marriott. M. MacLennan, president, M. Spence, past president, representatives of the Valley hospitals — A. Munro, I. Mellish and Mrs. A. MacNicholl, Mrs. G. Wilson representing the alumnae of Payzant Memorial Hospital, Mrs. T. Lockhart, treas., and Mr. and Mrs. H. Woodhead were seated at the head table. Mr. Woodhead was in charge of the musical program and sing-song that livened the evening. Five student nurses from Payzant Memorial Hospital were among the guests.

Payzant Memorial Hospital

Alumnae members held their first reunion this past fall. Miss Dorothy Percy of the Federal Department of Health was the guest speaker.

ONTARIO

DISTRICT 1

The annual district meeting was held in the Jeanne Mance Residence of the Hotel Dieu Hospital, Windsor, in mid-November. L. Barr and H. Rosati were in charge of registration proceedings. Father A. Finn pronounced the invocation and greetings from the City were expressed by Mayor Michael J. Patrick. The guest speaker was Mrs. Mary F. Strong from the R.N.A.O. provincial office. Her topic was "Labor Relations as They Affect Nurses in Ontario." A dinner meeting followed at the Elmwood Casino where Mrs. Cameron H. Montrose, Controller, City of Windsor was the guest speaker. She stressed the role of women in helping to shape the future and outlined the qualities needed for a profitable contribution.

CHATHAM

Public General Hospital

Mrs. G. Brisley was presented with a past president's pin at the annual alumnae banquet. Several class reunions were held on the day of the banquet and a number of nurses attended services in the hospital chapel on the following day. Coffee was served in the Board room following the service.

DISTRICT 5

TORONTO

Women's College Hospital

A hobby show, tea and bake sale were held in Burton Hall in mid-November. A drawing

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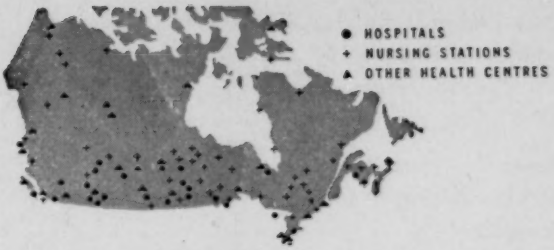

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(4) Regional Superintendent, 522 Dominion Public Building, Winnipeg 1, Manitoba.

(5) Zone Supervisor of Nursing, Box 292, North Bay, Ontario.

(6) Zone Supervisor of Nursing, P.O. Box 3427, St. Roch Branch, Quebec, Que.

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Chief, Personnel Division, Department of National Health and Welfare, Ottawa, Ontario.

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for a silver tea service, electric coffee pot and a beauty kit was a particular highlight. Proceeds of this event are to be used for the scholarship fund. Mrs. McKend has joined the teaching staff of the Hotel Dieu Hospital, Kingston. M. Janzen is working in a leprosarium in Viet Nam. D. Morehouse is assistant supervisor in the recovery room of Victoria Hospital, London and J. Haney is on the staff of the operating room. Mrs. G. Cowie Turner entertained members of her class at a reunion party. There was an attendance of 20. The student nurses sponsored a fashion show and acted as models as their special fund-raising project.

L. Bernache is an assistant head nurse on the staff of Mount Sinai Hospital, Toronto. Mrs. W. Harvey is doing private nursing in the Peterborough Civic Hospital. Sub/Lt. D. Stephenson recently spent some time in Esquimalt, B. C. on a course of study at H.M.C.S. Naden. W. Sims has accepted the position of assistant director of nursing education in her home school. Fifty-one new students forming the graduating class of '60 began their studies this fall.

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District 7

Kingston

Hotel Dieu Hospital

Over a year ago, the School of Nursing under the direction of Sr. Mooney initiated a parent-teacher group — a new venture intended to give the parents deeper insight into nursing education and to provide the instructors with information that might help them solve problems in dealing with student nurses. The second meeting of this group was held in October, 1957. This time discussions centred about the question of blind dates and stimulation of interest in hobbies. Several recommendations were made including one to increase the number of parent-teacher meetings held and one providing for an invitation to a representative group of students to attend such sessions. Parents expressed their views about the particular problems under discussion — some of those unable to be present sent in letters expressing their opinions. The next meeting is scheduled for the spring of this year.

QUEBEC

Montreal

Royal Victoria Hospital

Miss Ethel Reid, supervisor of the Ross Memorial Pavilion, who has been on the staff of the hospital for 42 years, retired recently. A tea was held in her honor late in October. Members of the board of governors, nurses, doctors and business personnel attended. Miss Reid, Miss H. L. Lamont and Mrs. E. Daly received the guests. Presiding at the tea tables were Miss M. Etter, Miss J. MacKay, Miss K. Cooke, Miss W. MacLean, Miss C. V. Barrett, Mrs. M. Butler, Mrs. S. Lewis and Mrs. J. G. Turner. Miss K. Cooke has succeeded Miss Reid and Miss A. Crickard has also joined the staff of the Ross office.

R. Smith '56, night supervisor at the Deaconess Hospital, Boston and Mrs. D. (Liddell) Vipond were recent visitors to the hospital. E. Watts '55 is enrolled in the public health course at Dalhousie University and M. Kingsmill has joined the staff of the Vancouver General Hospital.

Late in September the Kingston chapter met at the home of Mrs. M. (McLaughlin) Trotter with 11 members present. Guest speakers for the evening were Miss Winnifred MacLean who described recent developments about the hospital and Miss Margaret Kerr who spoke on her trip to the I.C.N. Quadrennial. M. Bellhouse who organized the chapter and has been its president for the past five years retired and has been succeeded by Mrs. H. (Tett) Mundell.

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Director of Nursing Service for 176-bed hospital with school of nursing. Full nursing staff presently available. Liberal personnel policies & salary. Apply Administrator, Victoria General Hospital, 424 River Ave., Winnipeg 13, Manitoba.

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Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

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Staff Nurses (3-11:30 shift) for orthopedic & intravenous medical/departments. Please apply Providence Hospital, 700 N.E. 47th Avenue, Portland 13, Oregon.

Registered Staff Nurses. Never a dull moment for the graduate nurses who decide they would like to join us at the University of Texas Medical Branch Hospitals. 40-hr. wk. in our air-conditioned hospitals leaving 128 hrs. to enjoy the beach & nearby resorts. Galveston boasts an average temperature in the low seventies which means that swimming, fishing, horseback riding & sailing can be enjoyed the yr. round. Positions available in the clinical area of your choice. Monthly salary begins at $290 for rotating — $304, for extended evenings or nights. Uniforms laundered free. Liberal personnel policies & opportunities for advancement. Comfortable air-conditioned residences including maid service at moderate cost. Excellent opportunities for advanced study leading to both B.S. & M.S. degrees. Write for further information to Director of Nursing Service, University of Texas Medical Branch Hospitals, Galveston, Texas.

Registered General Duty Nurses (2) immediately for 76-bed fully modern hospital on C.P.R. main line & Trans-Canada Highway to Calgary & Banff. Gross salary: $230 per mo. Perquisites $30. $5.00 increment every 6 mo. 8-hr. day, 44-hr. wk. 1 mo. annual vacation with pay. Sick leave with pay. Apply to Matron, Brooks Municipal Hospital, Brooks, Alta.

Registered or Graduate Nurses (2) for 18-bed General Hospital, situated on the beautiful Arrow Lakes, B.C. Standard salaries, semi-annual increases. 40-hr. wk. Holidays. 'Living-in' accommodations available at low cost. Apply to the Administrator, Arrow Lakes Hospital, Nakusp, British Columbia.

Registered & Licensed Practical Nurses (Immediately) for 36-bed General Hospital. Top salaries paid with other fringe benefits. Please write for further particulars to: Superintendent of Nurses, District Hospital, Altona, Manitoba.

Registered Nurse (1) for fully modern 30-bed hospital in northwest Manitoba. Excellent personnel policy & working conditions. 44-hr. wk., overtime pay. Gross starting salary: $250 per mo. less $30 maintenance. 4-wk. vacation with pay after 1-yr. service. All statutory holidays. Accumulative sick time. Apply Sec.-Treas., Roblin District Hospital, Roblin, Manitoba.

Registered General Duty Nurses (Immediately). Salary: $230 per mo. Excellent personnel policies. Apply Director of Nursing, General Hospital, Cobourg, Ontario.

Registered Nurse (1) for Margaret Cochenour Memorial Hospital (modern 15-bed) located on the lake in Red Lake mining district & tourist area. New nurses' residence beautifully furnished. Salary: $275 basic with increment plan. Maintenance including uniform laundry, $30 per mo. 44-hr. wk. Holidays. 4-wk. vacation with pay yearly. Transportation expense will be paid after 6-mo. employment. Apply I. MacNaughton, Matron, Cochenour, Ontario.

Registered General Duty Nurses (4) for 105-bed Pembroke Cottage Hospital as replacements for ones who have been married. Pop. of town, 15,000. 8-mi. from Camp Petawawa, 2-hr. from Ottawa & 4-hr. from Montreal with excellent train & bus service. Active, interesting community social life in heart of the beautiful Ottawa Valley. Active ski club, curling club & skating, also the home of the famous Pembroke Lumber Kings Hockey Team, 2-theatres & a "drive-in". Nurses residence is available if desired, 2 blocks from the hospital. Gross salary: $210-$235 with increase at the end of 6-mo. & 1 yr. 3-wk. vacation, 7 statutory holidays. 14-day sick leave. No night duty. Blue Cross Medical/Surgical participation. Forward application to the Director of Nursing, The Cottage Hospital, Pembroke, Ontario.

Registered Nurses for **General Staff Duty & Operating Room** in modern hospital opened February, 1956 & situated in the midst of one of Canada's most prosperous mining districts. Beginning salary: $240 per mo., plus annual bonus plan, merit increase in 6-mo. to $250 per mo., subsequent increases to $270. Sick leave accumulative to 60 days. Free laundering of uniforms. Partial refund of transportation. Apply Director of Nursing, Memorial Hospital, Regent St. S., Sudbury, Ontario.

Registered General Duty Nurses for County Hospital 45 mi. from center of Montreal with excellent bus service. Pleasant working conditions. Nurses' home attached to hospital. Attractive community social life. Two theatres, bowling, curling & dancing. 8-mi. from summer resort on Lake St. Francis & 12-mi. from U.S. border. Gross salary: $215 per mo. Three $5.00 increases at 6-mo. intervals to maximum $230. 44-hr. wk. 8-hr. duty, rotating shifts. Full maintenance available at $35 per mo. 1-mo. annual vacation, all statutory holidays. 2-wk. sick leave. Blue Cross paid. Apply: Mrs. M. G. Curran, R.N., County Hospital, Huntington, Quebec.

Registered Nurses for Tuberculosis Hospital: **Operating Room, Head Nurse, General Duty.** Salary dependent upon training & experience. Apply giving full details in 1st letter: Age, when available, salary expected, etc. to Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke St. E., Montreal 5, Quebec.

Registered Nurses for modern 60-bed General Hospital situated 40 mi. south of Montreal. Salary: $210 per mo., $5.00 increase every 6-mo. for 5 increases. Monthly bonus for permanent evening & night shifts. 44-hr. wk. Many attractive benefits. Board & accommodation available at minimum cost in new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Quebec.

Registered Nurse for fully modern 15-bed hospital. Regulation salary & benefits. Bonus of $180 after 1-yr. service. Apply Matron, Union Hospital, Maidstone, Saskatchewan.

Registered Nurses for newly constructed 640-bed hospital. Salary: $338-$392 per mo. Paid vacation, sick leave & other outstanding benefits. California registration or eligibility for registration required. Apply: Administrator, Kern General Hospital, Bakersfield, California.

Registered Nurses for 105-bed accredited General Hospital. Salary: $330-$360 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Director of Nurses, Glenn General Hospital, Willows, California.

Registered General Duty Nurses for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago. Base salary: $300. Additional differential of $30 for evenings & $20 for nights. 5 day wk. Good personnel policies. Apply Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Registered Nurses. Salary: $295, with periodic increases. Excellent personnel policies. For further information please contact Superintendent, City Hospital, Red Wing, Minnesota.

Registered Nurses. Positions located in Salem, Portland & eastern Oregon. Must have completed 3-yr. course of study at a recognized school of nursing. Salary range $295 to $400 (depending on qualifications). Room, board & laundry available for single persons at $40 per mo. Contact Oregon State Civil Service Commission, 102 Public Service Building, Salem, Oregon.

Registered General Duty Nurses (100-bed.) Good bedside nursing required. 40-hr. wk. Rotating duties. Excellent personnel policies. You can arrange for R.I. State Registration. Apply Nurse Director, Jane Brown Memorial Hospital, Providence 3, Rhode Island.

Graduate Nurses for 33-bed General Hospital 45 mi. from Sudbury. Salary: $265-$315. Half yearly increments. Blue Cross & laundry provided. Please apply Superintendent, General Hospital, Espanola, Ontario.

Graduate Nurses for new, very modern 88-bed hospital in a pleasant progressive town. Salary: $200 per mo. Annual increase $10 per mo. for 3 yrs. 2-wk. shift rotation, bonus for night shifts. 1 hr. drive to Toronto & several resorts. Local swimming pool, bowling alleys, skating, theatres etc. Apply Director of Nurses, Dufferin Area Hospital, Orangeville, Ont.

Graduate General Duty Nurses for tuberculosis sanatorium. Starting salary: $240, increments every 6-mo., maximum: $260. No night or evening duty. 5-day, 40-hr. wk. 4-wk. vacation with pay after 1 yr. service. Time & one-half for all statutory holidays worked. Pension plan & other benefits. Apply Superintendent of Nurses, Prince Albert Sanatorium, Prince Albert, Saskatchewan.

Graduate Nurses for new modern Mayo General Hospital, Yukon Territory. Previous obstetrical & operating room experience necessary. 14 adult beds, 3 cribs, 5 bassinets. Pleasant nurses' residence. Employment terms sent to applicants. Please apply to Matron.

General Duty Nurses. $255. 40-hr. wk. 28-day vacation yearly plus 10 statutory holidays. Sick leave 1½ days monthly, accumulative after 6-mo. Room & full board $25 per mo. Fare from Vancouver advanced or refunded after 6-mo. service. Apply Matron, St. George's Hospital, Alert Bay, British Columbia.

General Duty Nurses. Salary: $240-$280, $10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, 1 mo. vacation, Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

General Duty Nurses & Operating Room Nurses for 430-bed hospital; 40-hr. wk. Statutory holidays. Salary $240-$273. Credit for past experience & postgraduate training. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses (Immediately) to staff a new ward for General Hospital. Salary: $250. 40-hr. wk. 28-day vacation; 10 statutory holidays. Sick leave, full benefits. Accommodation in nurses' residence. Please apply Director of Nursing, Prince George & District Hospital, Prince George, British Columbia.

General Duty Nurse for 110-bed General Hospital. 40-hr. wk. Salary: $273. 1-mo. vacation after 1-yr. 10 statutory holidays. Sick benefits. Travelling allowance. Modern residence available. Apply giving particulars of experience & references to: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurses. Starting salary: $260 per mo. & 4 annual increments of 5% to B.C. reg'd nurses. $20 per mo. for one or more years university training & $10 per mo. for hospital postgraduate clinical training of not less than 4 mo. 28 days annual vacation after 1 yr. service, 10 statutory holidays per yr. 1½ days sick leave per mo. cumulative. Room rent at nurse's residence $20 per mo. Promotions to senior positions from permanent staff. For details apply Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.

General Duty Nurses — $250-$300. 40-hr. wk. $35 per mo. full maintenance, comfortable home close to hospital. 10 statutory & 28-day annual holiday. 1½ days sick leave per mo., accumulative indefinitely. Very active town, in world famous Cariboo country. Apply Director of Nurses, War Memorial Hospital, Williams Lake, British Columbia.

General Duty Nurses for new 85-bed hospital. Good salary & generous personnel policies. Apply to the Director of Nursing, Portage Hospital Dist. #18, Portage la Prairie, Manitoba.

General Duty Nurse: The Blanchard-Fraser Memorial Hospital (71-bed) located in Kentville, Nova Scotia, offers a General Duty Nurse ideal working conditions. 1 mo. annual vacation, excellent personnel policies plus modern living quarters with full maintenance in new nurses' residence. For further information apply to Superintendent of Nurses.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Duty Nurses. Starting salary: $235 monthly with additional $5.00 per mo. for each year experience since graduation up to 4-yr. Annual increment: $120. Maximum salary: $265. Blue Cross coverage paid by hospital. Room & board in nurses' residence: $45 monthly. 28-day vacation. Transportation costs refunded after 6-mo. employment. Apply Director of Nursing, General Hospital, Atikokan, Ontario.

General Duty Nurses for all departments. New addition to hospital recently opened. Good personnel policies. Apply to Director of Nursing, General Hospital, Belleville, Ont.

General Duty Nurses & Certified Nursing Assistants for 86-bed hospital. Living accommodation available. Collingwood is situated on Georgian Bay & is noted for its great skiing on the Blue Mountains, along with ice skating & curling on artificial ice. For further information apply Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

General Duty Nurses for all departments. Gross salary: $235 per mo. if registered in Ontario, $215 per mo., until registration has been established. $20 per mo. bonus for evening & $10, night duty; annual increment of $10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 12 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing, General Hospital, Oshawa, Ont.

Nurses — General Duty: $330 up plus $20 p.m. shifts. **Surgery:** $430 plus $10 call-out. 40-hr. wk. Social security; paid vacation; 10-day sick leave. Hospital group insurance. 5-yr. salary & benefit increment. Apply Director of Nurses, Corning Memorial Hospital, Corning, California.

General Duty Nurses (English speaking) for 466-bed hospital. Nurses' residence available. Salary: $315, California registered — $285, Canadian registered. $22.50 differential for 3-11 & 11-7 shifts. Apply Cedars of Lebanon Hospital, 4833 Fountain Ave., Los Angeles, California.

Attention General Duty & O.R. Nurses. 400-bed County Hospital located 2-hr. drive from San Francisco, ocean beaches or mountain resorts. **Surgery:** $349-$419 rotating call. **General Duty:** $304-$365 plus shift & service differential. 40-hr., 5-day wk. 3-wk. paid vacation, 11 paid holidays. Paid sick leave, retirement plan. Accommodation in nurses' home. Laundry & meals at reasonable rates. Must be eligible for California registration. Apply Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California.

General Duty Nurses for 600-bed teaching hospital in central California. In-service educational program. Salary: $337-$396. 40-hr. wk. 11 holidays annually. Retirement & sick leave plan. Differential of $20 per mo. for 3 p.m.—11 p.m. & $15 per mo. for 11 p.m. —7 a.m. Apply Personnel Director, 732 East Main St., Stockton, California.

General Duty Nurses, Operating Room Nurses for 64-bed acute treatment, fully accredited hospital in northern California. Excellent living conditions. For full details at once on salaries, working conditions, paid vacations, paid holidays, paid sick leave & other benefits apply to Director of Nursing Services, Woodland Clinic Hospital, Woodland, California.

Operating Room & General Duty Nurses for new 63-bed hospital, 35-mi. from Vancouver. Hospital expected to open about January, 1958. Apply Director of Nursing, Maple Ridge Hospital, Haney, British Columbia.

Operating Room Nurse (Immediately — 2 or 3 yrs. experience in O.R. technique preferable). Salary: $250 basic, plus $10 'on-call' allowance, plus credit for P.G. & 2-yr. satisfactory experience. Board & room available at $49.50 per mo. Apply stating age, qualifications & experience to Director of Nursing, Prince George & District Hospital, Prince George, British Columbia.

Laboratory Technicians (For U.S.A.) experienced in all clinical procedures of General Hospital Laboratory. Interesting position. Advancement. Apply Morristown Memorial Hospital, Morristown, New Jersey.

Superintendent for 16-bed hospital. Good salary. 44-hr. wk. 3-wk. vacation plus statutory holidays. Sick leave benefits. Apply to the Shelburne District Hospital, Shelburne, Ontario.

Registered General Duty Nurses for new 30-bed hospital R.N.A.B.C. policies in effect. Apply Matron, Creston Valley Hospital, Creston, British Columbia.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary: $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in psychiatry & pediatrics on a segrated service. Apply Superintendent, Community Hospital, Alamosa, Colorado.

DIRECTOR OF NURSING

For 140-bed sanatorium serving a 5-county area. Opportunity to have active part in broad anti-tuberculosis program. Investigation. Treatment. Affiliation course. Rehabilitation. Mobile X-ray equipment. Apartment — Pension Plan — Salary open.

APPLY TO MEDICAL SUPERINTENDENT, FREEPORT SANATORIUM, KITCHENER, ONT.

APPLICATIONS WILL BE ACCEPTED BY THE

SECRETARY OF THE BOARD OF GOVERNORS,

KINGSTON GENERAL HOSPITAL, KINGSTON, ONTARIO

for the position of

DIRECTOR OF NURSING

For Modern 42-bed Hospital — Operating Room Nurse, starting salary, $260. **General Duty Nurses,** starting salary for new graduates, $245, with 2 years experience, $255, provided Ontario registration is obtained. Annual increments; 6% bonus for shift work. 44-hr. wk. with 8 paid statutory holidays. Annual vacation, 21 days first year, 28 days, second year. 1½ days sick time per mo. Good living accommodations available. Apply to Superintendent of Nurses, General Hospital, Sioux Lookout, Ontario.

Pediatric Nurses (Interested in total pediatric experience) for 100-bed service in new air-conditioned University teaching hospital. Experience includes premature, isolation, surgical specialties in addition to general pediatric nursing. Active inservice participation. Salary: For rotation, $290 per mo., evening or night, $304. Good personnel policies. Abundant recreational facilities. Apply Director, Nursing Service, University of Texas Medical Branch Hospital, Galveston, Texas.

Plastic Surgery, Jaw Injuries & Burns Centre, St. Lawrence Hospital, Chepstow, Mon. England. (127 Plastic Surgery, 50 Orthopedic Beds). 6-mo. postgraduate course on Plastic Surgery for Canadian trained nurses. Commences April 1st. Full national salary scale for Staff Nurses paid. Posts afford an opportunity of gaining further experience & seeing something of England. Must pay own fare to England & stay at least 6-mo. Experience given in all phases of plastic work. Write giving two references to T. A. Jones, Group Secretary, 64 Cardiff Road, Newport, Mon. England.

Baker Memorial Sanatorium, Calgary, Alberta, offers to Graduate Nurses a 6-mo. postgraduate course in Tuberculosis. Salary: $3,240 to $3,720 per annum. Openings also available for **General Duty Nurses.** Residence with board, if desired, $30 per mo. Excellent holiday, sick leave & pension benefits. Apply to: Superintendent of Nurses.

Experienced Delivery Room Nurse for obstetrics & **Assistant Operating Room Nurse** for 30-bed hospital. To start January 15 - 30. Preferably bilingual. Starting salary dependent on experience; minimum: $300 per mo. Please reply directly to Dr. D. S. Thurber, Medical Director, Boisvert Memorial Hospital, Baie Comeau, Quebec.

Health Nurse for Royal Alexandra Hospital & school of nursing, Edmonton, Alberta. Position requires a nurse with diploma or degree in Public Health Nursing. Applications to be made to Director of Nursing, stating qualifications & experience.

X-Ray Technician, Laboratory Technician for active 35-bed hospital 50 miles from Toronto. Good living accommodation in nurses' residence. Good personnel policies. For further information please apply to: Superintendent, Stevenson Memorial Hospital, Alliston, Ont.

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IN

MEDICAL & SURGICAL NURSING

PEDIATRIC NURSING

Recent university postgraduate course and teaching experience preferred. This is a modern 300-bed hospital, located in a progressive, industrial city of 45,000 population. The school for nurses is well-equipped, and has a total student enrolment of 72.

Annual starting salary: $3,419 with increments to $3,887.

Apply:

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Residence, Cook County School of Nursing

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Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at $330.00 for a 37½ hour week. And you're only minutes from Chicago's fabulous Loop and local universities.

Graduate Nurses! Positions open in all clinical areas! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

THE PROVINCE OF MANITOBA

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AN ASSISTANT SUPERINTENDENT OF NURSING

for the Hospital for Mental Diseases,
Selkirk, Manitoba.

QUALIFICATIONS: Registered Nurse preferably with Mental Nursing Certificate.

DUTIES: To assist the Superintendent of Nursing in the supervision and direction of nursing staff and to assist in the teaching program under the direction of the Instructress of Nursing.

SALARY RANGE: $3120. - $4020. per annum, less $300. per annum for full maintenance.

The above position offers full Civil Service benefits, liberal sick leave with pay, four weeks' vacation annually with pay and pension privileges.

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247 Legislative Buildings,
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The
Ontario Society for Crippled Children

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EXPERIENCED PUBLIC HEALTH NURSES

GOOD SALARY RANGE

and

PERSONNEL POLICIES

For further information apply to:

THE SUPERVISOR OF NURSING SERVICES,
ONTARIO SOCIETY FOR CRIPPLED CHILDREN,
92 COLLEGE STREET, TORONTO 2, ONTARIO

Obstetrical Supervisor for new department with rooming-in facilities & regular postpartum care. Closed staff. Responsible for delivery & labor section, constant care unit, postpartum & nursing division. B.S. Degree required with experience as head nurse. For further information, please write Mrs. Irene D. Lewis, Personnel Director, The Cleveland Clinic Foundation, 2020 E. 93rd St., Cleveland 6, Ohio.

Wanted — Professional Nurses eligible for registration in Washington, D.C. Staff Nurse positions in 620-bed hospital for medical and surgical diseases of the chest; salary $4,080 per annum; $135 yearly increment; vacation, sick leave, retirement policies; 40-hour week; rotating shifts; active staff orientation program, progressive education programs for staff, student and patient personnel; uniforms laundered free; comfortable maintenance available at modest rates. Opportunity for university study. Write to Director of Nursing, Glenn Dale Hospital, Glenn Dale, Maryland.

Registered Nurses for modern 52-bed hospital in English speaking community, 50-mi. from Ottawa. Salary: $175 per mo., $10 extra for evening & night duty (two weeks). Straight 8-hr. with full maintenance. 44-hr. wk. Annual leave, statutory holidays & sick leave. Fare advanced if required. Apply Superintendent, Pontiac Community Hospital, Shawville, Que.

Operating Room Nurse. Starting salary: $275 minimum with postgraduate course, $310 maximum with 3-yr. experience or more. Iron mining town. Excellent accommodation & personnel policies. Transportation allowance after 3-mo. service. Apply Superintendent, Lady Dunn Hospital, Jamestown, Ontario.

Public Health Nurse. 5-day wk. Salary with Public Health experience, $2,940 to $3,660. Apply to Dr. Hugh M. Brown, Director, Athabasca Health Unit, Athabasca, Alberta.

Public Health Nurse (Qualified). Generalized program, includes some bedside nursing. Salary: $3,200 to $4,250. Annual increment: $150. 5-day wk. Car provided or car allowance. Apply to Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ontario.

Part-time Public Health Nurse, or nurse with equivalent experience, for school nursing in the Town off Mount Royal. Excellent working conditions. Write, stating qualifications & salary expected to: Dr. G. H. Nickerson, Medical Health Officer, 20 Roosevelt Ave., Town of Mount Royal, Quebec.

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$2,700 — $3,540

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Applications will be considered from Registered Nurses without Public Health training but with University entrance qualifications.

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To begin duties January, 1958

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Employer shared Pension & Hospitalization Plans.

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EXECUTIVE SECRETARY TREASURER

The Saskatchewan Registered Nurses' Association invites applications for the position of Executive Secretary Treasurer.

Applicants must have experience in Nursing Service and Nursing Education.

Experience or postgraduate study in Administration would be an asset.

Apply in writing stating qualifications, experience and salary expected to:

MISS LUCY D. WILLIS, PRESIDENT, S.R.N.A.,
SCHOOL OF NURSING,
UNIVERSITY OF SASKATCHEWAN,
SASKATOON, SASKATCHEWAN.

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PUBLIC HEALTH NURSES

for

SENIOR AND STAFF POSITIONS IN HEALTH UNITS

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New Salary Schedule in effect since 1st April, 1957.

Application forms and details from:

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OF PUBLIC HEALTH,
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EDMONTON, ALBERTA

OBSTETRICAL SUPERVISOR

Salary range: $298-$328, $10 extra for P.G. in obstetrics. Full charge of new 15-bed unit, case room & nurseries. Perquisites include: 1-mo. annual vacation, 10 statutory holidays, sick leave to 36 days, travelling allowance & others. For further information please apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, PRINCE RUPERT, BRITISH COLUMBIA.

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THE DIRECTOR, PUBLIC HEALTH NURSING, DEPT. OF HEALTH, VICTORIA, B.C. OR
THE CHAIRMAN, B.C. CIVIL SERVICE COMMISSION, 544 MICHIGAN ST., VICTORIA, B.C.

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REQUIRED IMMEDIATELY

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DIRECTOR OF NURSING,
MEMORIAL HOSPITAL,
SUDBURY, ONTARIO

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1. **A CLINICAL COORDINATOR:**

   To coordinate & further develop the orientation program for the graduate nurses. To administer & further develop the clinical instruction program for the student nurses.

   Qualifications:

   a. Minimum, a B.A., or B.Sc. degree in nursing education.
   b. Desirable but not essential, a Master's degree or equivalent education & experience.

2. **AN ASSOCIATE DIRECTOR OF NURSING EDUCATION:**

   To supervise & assist in the organization & development of the educational program for the school of nursing.

   Qualifications:

   a. Minimum, a B.A., or B.Sc. degree in nursing with considerable experience in supervisory & administrative capacities.
   b. Desirable but not essential, a Master's degree or equivalent education & experience.

3. **AN OPERATING ROOM SUPERVISOR.**
4. **CLINICAL INSTRUCTORS IN MEDICINE & SURGERY.**
5. **GENERAL DUTY NURSES FOR ALL SERVICES.**

Please send applications direct to: **THE DIRECTOR OF NURSING, THE WINNIPEG GENERAL HOSPITAL, WINNIPEG 3, MANITOBA.**

GRADUATE NURSES — SUBURBAN TORONTO

Are invited to enquire re: employment opportunities in a well-staffed new 125-bed hospital in suburban west Toronto. General duty salary range: $225 to $275 per mo. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH ST. WESTON, TORONTO 15, ONTARIO. CHerry 4-5551.

GRADUATE STAFF NURSES — YOU WILL LIKE IT HERE

Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $295 per mo. 6 holidays, sick leave, 3 wk. vacation.

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Director — Nursing Service, University Hospitals of Cleveland, Ohio.

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REGULAR AND VACATION RELIEF POSITIONS IN
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1500 bed teaching hospital, heart of British Columbia's medical centre

ATTRACTIVE PERSONNEL POLICIES
Salary $249 — $289 per month. 5 day, 40 hour week

(Eligibility for registration in B.C. necessary)

PLEASE APPLY TO PERSONNEL DEPARTMENT, VANCOUVER GENERAL HOSPITAL, VANCOUVER, B.C.

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*Ratner, Bret; Crawford, L. V.; and Flynn, J. G.: Amer. J. Dis. Child., 91:593, 1956

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